DEPT.- 65

JOB- 21

REEL- 47

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health , BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KP 29007

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73020

CERTIFICATE OF DEATH.

90 D73020

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hackett

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) #0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) nVirginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1923

17

I HEREBY CERTIFY, That I attended deceased from February 23, 1923, to February 23 1923, that I last saw him alive on February 23, 1923, and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Clyde A. Reed, M. D.

2-24-23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health. — ADDRESS

Per. Wm. E. WOODALL

FEB 26 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73021

CERTIFICATE OF DEATH.

D73021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 Fait ave ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kamienski

(a) RESIDENCE NO. 2406 Fait ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Josephine Kamienski

6 DATE OF BIRTH (month, day, and year) April 23 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) poland

PARENTS

10 NAME OF FATHER Luke Kamienski

11 BIRTHPLACE OF FATHER (city or town) (State or country) poland

12 MAIDEN NAME OF MOTHER Mary unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) poland

14 Informant (Address) Josephine Kamienski 2406 Fait ave

FEB 26 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 16, 1923, to Feb 24, 1923.

that I last saw him alive on ....., 1923

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Gardner, M. D.

2/26 1923 (Address) 1918 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 27 1923
20 UNDERTAKER	ADDRESS
John M Otchey	1803 Bank St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSES is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73022 D73022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 N Gilford Ave ST.: 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie McElfresh

(Residence in Baltimore: No. 2027 N Gilford ave St.; 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 17, 1851
(Month) (Day) (Year)

7-AGE. 71 yrs. 6 mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Frederick Co Md

PARENTS.

10-NAME OF FATHER, Thomas McElfresh

11-BIRTHPLACE OF FATHER (State or Country), Frederick Co Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Walter Smith

(Address) 4212 Ridgewood Ave

15-

Robert P. Harrison,

Filed FEB 26 1923, 191

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 1923, to Feb 25 1923, that I saw h Cr alive on Feb 24 1923, and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) 5 yrs. mos. ds.

(Signed) H G Owens M. D.

2/26, 1923 (Address) 1210 W North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, Feby 1, 1923

20-UNDERTAKER Harry R Annacos — ADDRESS 4214 Ridgewood Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Blks.

D73023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73023

CERTIFICATE OF DEATH.

106-00

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bay View Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Gassaway

(a) RESIDENCE NO. 206 Annapolis Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Gassaway

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address)

15 Robert P. Harrison, ..., 19 ..... Registrar

Burial Permit Clerk.

FEB 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febr. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Febr. 24, 1923, to Febr. 25, 1923, that I last saw her alive on Febr. 24, 1923, and that death occurred, on the date stated above, at 835 a m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) disease Arteriosclerotic brain (duration) 38 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Bay View Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. H. Dorsett, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feby 27 1923

20 UNDERTAKER Harry N. Amass X4204 Ridgewood Ave ADDRESS

Spec.—1-10-21—MA 1—1500 lbs.

D73024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73024

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 E. Sharp ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta J. Meyers

(a) RESIDENCE NO. 812 E. Sharp ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Meyers

6 DATE OF BIRTH (month, day, and year) Dec 4th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germ.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ

14 Informant Frank J. Thacker

(Address) 736 Hanover St.

15 Filed FEB 26 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 19th, 1923, to Feb 25th, 1923, that I last saw her alive on Feb 24th, 1923 and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) D Harry Pleibel M.D.

2/26, 1923 (Address) 1224 E Hanover Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 27 1923
20 UNDERTAKER C Schumacher Son	ADDRESS 1039 Hanover St

Spec—12-23-21—E.B.R.S.—400 Bks.

D73025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73025

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Homewood Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John A. Elsasser

(a) Residence No. 1227 Madison Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sue Elsasser

6-DATE OF BIRTH (month, day and year) Oct. 25-1850

7-AGE, 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Prop. Trans. 886

(b) General nature of industry, business, or establishment in which employed (or employer) Falkenau Bench

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, John A. Elsasser

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Del

12-MAIDEN NAME OF MOTHER, Ella Frazier

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Del

14- (Informant) Sue Elsasser

(Address) 1227 Madison Ave

15-

Filed..... Robert P. Harrison, Registrar.

FEB 26 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feby 25-23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1922 to Febr. 25, 1923, that I last saw h.. alive on Febr. 25, 1923 and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (chronic)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James C. Clark M. D.

Feb. 26, 1923 (Address) Lutherville Opp. Clan Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Middletown Del. DATE OF BURIAL, 2-28 1923

20-UNDERTAKER. Geo. J. Smith ADDRESS 1532 Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73026

CERTIFICATE OF DEATH.

101-00 D73026

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Kerrigan

(a) RESIDENCE. No. 3046 W. North Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 4, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sugar Ref.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Patrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Campbell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Teresa Kerrigan.

(Address) 3046 N. North Ave.

15 Filed ..... Robert P. Harris, ... Registrar

8 26 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to Feb. 23, 1923, that I last saw him alive on Feb. 23, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency—

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kiagen, M. D.

(Address) St. Joseph's Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Feb 27 1923
20 UNDERTAKER	ADDRESS
Margaret D. Flynn	1422 Light St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D73027 HEALTH DEPARTMENT—CITY OF BALTIMORE D73027

CERTIFICATE OF DEATH. 181-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 3726 Monastery Ave St., 20 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George T. Childs

(Residence in Baltimore: No. 3726 Monastery Ave St. yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word): Widower

6-DATE OF BIRTH: August 2nd (Month) (Day) 1843 (Year)

7-AGE: 79 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Candy Maker

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS:

10-NAME OF FATHER: John T. Childs

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Sarah S. Crowl

13-BIRTHPLACE OF MOTHER, (State or Country): Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T Childs

(Address) 3726 Monastery Ave

15- Robert P. Harrison, 192.... Registrar.

FEB 26 1923 Burial Permit Clerk.

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 26 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas

Accident, Gas Stove Failed

1. Immediate (Duration) Instantaneous ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James McHenry M. D. (Coroner.)

Feb 26 1923 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Co DATE OF BURIAL, Feb 28 1923

20-UNDERTAKER, Jacob B. Cook ADDRESS 1003 W Balto St

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73028

CERTIFICATE OF DEATH.

90 ✓ D73028

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2534 Hollins ST. 20 WARD.

2-FULL NAME Charles H. Stamm

(a) RESIDENCE. No. 2534 Hollins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? 52 yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Lina Stamm

6 DATE OF BIRTH (month, day, and year) Feb 13-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	✓	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Pork Butcher

(b) General nature of industry, business, or establishment in whirh employed (or employer): ✓

(c) Name of employer: ✓ 013

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Ludwig Stamm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Stamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lina Stamm
(Address) 2534 Hollins St.

15 Filed FEB 26 1923

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 1917 to Feb 24 1923 that I last saw him alive on Feb 24 1923 and that death occurred, on the date stated above, at 11-15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Valvular Heart Disease

(duration) Over 6 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) None

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Baker, M. D.

Feb 25 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 27 23 19
20 UNDERTAKER	ADDRESS
George Schwab	1101 Fulton Ave.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of (illegible) TION is very important. See instructions on back of certificates.

D73029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at St. Joseph's Hospital Registered No. C.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine McFarland

(Residence in Baltimore: No. Texas Md. St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	single

6-DATE OF BIRTH. March 26/21 1.....
(Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jno. L. McFarland

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Ida E. Williams

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jno. L.McFarland
(Address) Texas Md.

15- Robert P. Harrison,
3 26 1923 192..... Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2/26/23, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) had that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(over)

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Probably Acute Encephalitis (Duration) 36 to 48 hrs

(Signed) J. S. Walker (Coroner) M. D.

1/26/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Joseph Cemetery.	Feb 27, 1923
20-UNDERTAKER.	**ADDRESS**
Geo. J. Ruth	1735 Harford Ave.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73030

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73030

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2038 Robb ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dixon Lewis

(a) RESIDENCE. NO. 2038 Robb ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Madelmie Lewis

6 DATE OF BIRTH (month, day, and year) June 7 1899

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Old Bay Line

(c) Name of employer Steamship Co

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Chas Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eddie Calhoun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sadie Lewis (Address) 2038 Robb St

15 FEB 26 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22 1923, to Feb. 24th 1923, that I last saw h im alive on Feb 24th 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Norfolk Va

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. F. Smith M. D.

2-26 1923 (Address) 112 W Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Feb 28 1923
20 UNDERTAKER	ADDRESS
E A Wiedefeldt	501 Park Ave

NOTICE TO PHYSICIANS AND UNDERTAKERS—RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D73031 D73031 129

PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 720 E 21st St. 9 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Selway

(Residence in Baltimore: No. 720 E 21st St.)

St.: 65 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Aug (Month) 8 (Day), 1860 (Year)

7-AGE: 90 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Ship Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE (State or country): England

PARENTS

10-NAME OF FATHER: James Selway

11-BIRTHPLACE OF FATHER (State or country): England

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Selway

(Address) 720 E 21st St

15. Filed ..... 19.. Robert P. Harrison, Burial Permit Clerk — REGISTRAR

B 26 1923

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: February (Month) 23 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1st 1922 to February 28th 1923

that I saw h[illegible] alive on February 22nd 1923

and that death occurred, on the date stated above, at 5[illegible] m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) P E Filby M. D.

Feb 26, 1923. (Address) 5W E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Feb 27, 1923

20-UNDERTAKER: E A Woodfield Jr — ADDRESS: 501 E 22 St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73032

CERTIFICATE OF DEATH.

1-002 D73032

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 Druid Hill Ave WARD 13)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Pletzer

(a) RESIDENCE No. 2406 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht.	Married

5a If married, widowed, or divorced (or) WIFE of Clarence Pletzer

6 DATE OF BIRTH (month, day, and year) Jany 24th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	33	one	2	

8 OCCUPATION OF DECEASED Cashier

(a) Trade, profession or particular kind of work Cashier Dept 009

(b) General nature of industry, business, or establishment in which employed (or employer) Cashier at bath

(c) Name of employer Curtain Park

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. Scott

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Clarence Pletzer
(Address) 1506 Pinkney St

15 Filed 1923 Robert P. Harrison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17

I HEREBY CERTIFY, That I attended deceased from January 25, 1923, to July 26, 1923, that I last saw him alive on July 25, 1923, and that death occurred, on the date stated above, at 4.15a m.

The CAUSE OF DEATH* was as follows:

Paratyphoid

(duration) yrs 3 1 days ds.

CONTRIBUTORY (Secondary) Congestion of both Lungs

(duration) yrs. mos 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Health Dept. Lab

(Signed) E A Smith, M. D.

July 26 1923 (Address) 1605 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 28 1923
20 UNDERTAKER	ADDRESS
William Bak	5026 Reisterstown

Burial Permit Clerk.

B. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 26 1923

D73033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73033

CERTIFICATE OF DEATH.

181-001

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1329 N. Fulton Ave 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Harry Elmer Byers

(Residence in Baltimore: No. 1329 N. Fulton Ave St. 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	Married

6-DATE OF BIRTH, Jan. (Month) 10 (Day), 1883 (Year)

7-AGE, 40 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer): Himself.

9-BIRTHPLACE, (State or Country), Carroll Co. Md.

PARENTS.

10-NAME OF FATHER, Frederick Byers.

11-BIRTHPLACE OF FATHER (State or Country), Westminster Md.

12-MAIDEN NAME OF MOTHER Susie Byers.

13-BIRTHPLACE OF MOTHER (State or Country), Westminster Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Harry Byers.

(Address) 1329 N. Fulton ave.

15-

Filed Feb 26 1923 Robert F. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 25 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia from illuminating gas (Illuminating gas) Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute alcoholism

(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb 26 1923 (Address) 200 N Greene St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Westminster Md.	2/27, 1923
20-UNDERTAKER	ADDRESS
Wm. Cook.	502 E Pratt st

B. 26 1923

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Blks.

D73034

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 D73034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Shipley.

(a) RESIDENCE NO. 310 Cold Spring Lane WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 24 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 360

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel K Shipley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Effie Cadow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Samuel K. Shipley (Address) 310 Cold Spring Lane

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1923, to Feb 25, 1923, that I last saw him alive on Feb. 25, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Haemotoma
Rapid delivery, instr.
in Eclampsia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Weakness of heart action (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? Visible

(Signed) Ed Smith, M. D.

2/26, 1923 (Address) 1605 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Md — DATE OF BURIAL Feb 27 1923

20 UNDERTAKER Geo. R. Weer — ADDRESS Sykesville

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D73035

D73035

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 Ellamont ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley E. Abrams

(a) RESIDENCE. NO. 200 Ellamont ST., 20 WARD. Life

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 4-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Harry Abrams

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Ida Braginsky

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant S. Abrams
(Address) 200 Ellamont St

15 FEB 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/24 1923, to 2/26 1923,
that I last saw h alive on 2/25/23 1923,
and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Ac Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ac. Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) W. A. Krull, M. D.

2/26, 1923 (Address) Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Circle Mt. Carmel	2-27 1923

20 UNDERTAKER Jack Lewis, ADDRESS 1439 E Balto.

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WORK—WRITE PLAINLY, USING INK—

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73036

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Madison Avenue ST. 14 WARD)

2-FULL NAME Etta Pate

(a) RESIDENCE. No. 1402 Madison Avenue WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Moses Pate

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 60 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Hybrid Mix

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Flora —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Baltimore St

15 FEB 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1923. to Feb. 25, 1923.

that I last saw her alive on Feb. 25, 1923.

and that death occurred, on the date stated above, at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Linder, M. D.

, 19 (Address) 1404 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balt Hebrew Cem

DATE OF BURIAL: 2/28 1923

20 UNDERTAKER: Jack Lewis 1439 E Baltimore St

ADDRESS

FOR PERMANENT RECORD, WITH ENTRIES, INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D73037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 100-001 D73037

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 131 N. Exeter St.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Cohen

(Residence in Baltimore: No. 131 N. Exeter St.; 30 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January ....., 1857
(Month) (Day) (Year)

7-AGE, 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Baltimore St

15- FEB 27 1923 ROBERT R. KRAUTER,
Filed ....., 191.... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2/26/23, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I saw h..... alive on ....., 191...,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Union Cem — DATE OF BURIAL, 2-27-1923

20-UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore St

D73038

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D73038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1623 Jefferson St. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Yarbrough

(Residence in Baltimore: No. 1623 Jefferson St. St. (yrs. 2) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	black	single

6-DATE OF BIRTH. April 18/23 (Month) (Day) 1917 (Year)

7-AGE. 5 yrs. 10 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). N.C.

PARENTS.

10-NAME OF FATHER. R.S.yarbrough

11-BIRTHPLACE OF FATHER. (State or Country). N.C.

12-MAIDEN NAME OF MOTHER. Nellie Austin

13-BIRTHPLACE OF MOTHER. (State or Country). N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R.S.Yarbrough

(Address) 1623 Jefferson

15- Filed FEB 27 1923, 192.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb.25/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 3 ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J.H.Kalin M. D. (Coroner.)

2/26/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Feb. 27, 1923

20-UNDERTAKER. Chas. D. Johnson

ADDRESS 1116 N. Carey St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D73039

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D73039

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 730 W. Saratoga St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph J. Davis

(Residence in Baltimore: No. 730 W Saratoga St. St.; Yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col.	Sngl

6-DATE OF BIRTH. Aug (Month) 20 (Day) 1922 (Year)

7-AGE. yrs. 6 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Balt City

PARENTS.

10-NAME OF FATHER. Jm Davis

11-BIRTHPLACE OF FATHER, (State or Country) Dont Know

12-MAIDEN NAME OF MOTHER, Rosie Williams

13-BIRTHPLACE OF MOTHER, (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 915-Penna ave

15- Filed FEB 27 1923 192.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, autopsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Dont Know (Duration) yrs. mos. ds.

(Signed) W. H. Freeman M. D. (Coroner.)

2-26 1923 (Address) 117 W Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	2-27-1923
20 UNDERTAKER, Dan'l Easton	ADDRESS 915 Penna ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73040

CERTIFICATE OF DEATH.

90 D73040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malachia Distance

(a) RESIDENCE NO. 742 Bradley St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph Distance

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records.

(Address)

15 Filed FEB 27 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from February 13 19 23 to February 25 1923.

that I last saw him alive on February 25, 1923,

and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

2-26-19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 2-28- 1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Genias Scott

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73041 ✓D73041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 129

CITY OF BALTIMORE (No. 740 George ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jenias Scott

(Residence in Baltimore: No. 740 Georges St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.): Married

6-DATE OF BIRTH, ..., 1886
(Month) (Day) (Year)

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stoker
(b) General nature of industry, business, or establishment in which employed (or employer): Steamer

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER: Dnt Know

11-BIRTHPLACE OF FATHER (State or Country): Dnt Know

12-MAIDEN NAME OF MOTHER: Dnt Know

13-BIRTHPLACE OF MOTHER (State or Country): Dnt Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Scott

(Address) 740 George St

15- Filed FEB 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 26, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 17 1923, to Feb 26 1923, that I saw h[illegible] alive on Feb 25 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hepatitis

(Duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John C Stamps M. D.

2-26, 1923 (Address) 704 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, 2-28, 1923

20-UNDERTAKER Daniel Corbin — ADDRESS 916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 ✓ D73042

D73042 CERTIFICATE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. 1011 N. Stricker ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius A Lee

(a) RESIDENCE NO. 1011 N. Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred / yrs. / mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23. 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Zealous Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rose Bell Coltrain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Zealous Lee
(Address) 1011 N Stricker

15 Filed FEB 27 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to Feb 24, 1923 that I last saw him alive on 2-24-, 1923 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Grippe

3 wk (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coeff 1 wk (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1011 Stricker

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm R Boston, M. D.

Feb 25 1923 (Address) 1618 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ottawa mon Mfg Essex Mass	Feb 27 1923

20 UNDERTAKER Sam'l W. Chase & Son ADDRESS 1400 Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001 D73043

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1326 N. Calhoun ST. 15 WARD)

2-FULL NAME Elizabeth Gertrude Biddle

(a) RESIDENCE. NO. 1326 N. Calhoun ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Biddle

6 DATE OF BIRTH (month, day, and year) Feb 27. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Perry Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chesterlown Md

12 MAIDEN NAME OF MOTHER Anna Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chesterlown Md

14 Informant Annie Dixon
(Address) 1843 Fairmount St

15 Filed FEB 27 1923 Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25 1923

17 I HEREBY CERTIFY, That I attended deceased from February 16, 1923, to Feb 25, 1923, that I last saw h.. alive on Feb. 25, 1923, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) ... yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) 3rd attack.

Fourth attack (duration) 10 yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H Wight, M. D.

2/26, 1923 (Address) 1709 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W Auburn	2/28 1923
20 UNDERTAKER	ADDRESS
Sam'l W Close Son	1406 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D73044

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1813 N Lexington ST., 20 WARD)

2-FULL NAME John J Pollard

(a) RESIDENCE NO. 1813 N Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Aug 14, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	70	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Patrick Pollard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Crowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): John Stump 1813 W Lexington St

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 18, 1923, to Feby 25, 1923, that I last saw him alive on Feby 24, 1923, and that death occurred, on the date stated above, at 8-10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Paralysis)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? ✓

What test confirmed diagnosis? .....

(Signed) Wm O'Neill M. D.

Feb 26, 1923 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Mar 1 1923

20 UNDERTAKER: John J Fields — ADDRESS: 1200 W Fayette

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1902 Rosaria Liberto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73645

CERTIFICATE OF DEATH.

74-001 D73045

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 807 W North av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosaria Liberto

(Residence in Baltimore: No. 807 W North av St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

Husband of PIETRO SALVATORE LIBERTO

6-DATE OF BIRTH, Dec 21 25, 1850 (Month) (Day) (Year) 30

7-AGE, 72 yrs. 2 mos. 5 ds. 65

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy - Cefalu

PARENTS.

10-NAME OF FATHER, Salvatore Barranco

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosa Cumbo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Marion Schmeltz

(Address) 408 N Mulberry

15-

Filed FEB 27 1923 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 26, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1923, to Feb 26 1923, that I saw h[illegible] alive on Feb 25 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Cardio Respiratory Failure ?

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Joseph E Sidlow M. D.

Feb 27, 1923 (Address) 1516 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, W M Roulson — DATE OF BURIAL, Feb 28, 1923.

20-UNDERTAKER Catholic Cemetery — ADDRESS 2238 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73046

CERTIFICATE OF DEATH.

131 ✓ D73046

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Cimino

(a) RESIDENCE NO. 4826 Park Heights Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
38	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Addie Cimino

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Municipal Hospital Records. (Address)

FEB 27 1923

15 Filed ....., 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 19 19 23, to February 25 19 23.

that I last saw him alive on February 25, 19 23.

and that death occurred, on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Congenital) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde M. Reese M. D.

2-26-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb. 27 1923

20 UNDERTAKER: Geo. J. Reuter ADDRESS: 1735 Harford Ave.

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Jno G Aderon

D73047 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D73047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — City of BALTIMORE: (No. 620 N. Franklin St., St., 17 Ward) — Registered No. C. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F Aderon

(Residence in Baltimore: No. 620 N Franklin St.; yrs., 78 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word)
Male.	White	Sgle

6-DATE OF BIRTH. Feb (Month) 20 (Day) 1 (Year)

7-AGE. 78 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country). Balt md

PARENTS.

10-NAME OF FATHER. Jno Aderon

11-BIRTHPLACE OF FATHER, (State or Country). Balt City

12-MAIDEN NAME OF MOTHER. Eliz Strouss

13-BIRTHPLACE OF MOTHER, (State or Country). Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Stouss

(Address) 620 N Franklin

15. Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

FEB 27 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... ~~Inquest, or autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Jorgensen M. D. (Coroner.)

2-26 1923 (Address) 117 W Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Baltimore Cemetery	Feb 27 1923
20-UNDERTAKER,	**ADDRESS**
W M Routson	2238 N Howard

Spec. 1-1021 M&T 1500 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73048

CERTIFICATE OF DEATH.

101-001

D73048

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Warner ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Harmon

(a) RESIDENCE NO. 906 Warner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1843

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
60 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Shucker

(b) General nature of Industry, business, or establishment in which employed (or employer) 049

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Fannie Harmon

(Address) 906 Warner St

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 24, 1923,

that I last saw him alive on Feb 23, 1923,

and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Hollerbach M. D.

(Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Feb 27 23

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Uphill St

...ation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73049

11-001

CERTIFICATE OF DEATH.

D73049

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Leadenhall St. 12 Ward)

2-FULL NAME Ruth Green

(a) RESIDENCE NO. 803 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 2 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov, 28, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Alexander Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Lillian Boardley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Lillian Green

(Address) 803 Leadenhall

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb, 21, 1923, to Feb, 25, 1923, that I last saw h[er] alive on Feb, 25, 1923, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) David Franklin, M. D.

2/26 1923 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb. 28 1923
20 UNDERTAKER	ADDRESS
Jno W. Joadem	1412 Mt St

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73050

CERTIFICATE OF DEATH.

117 D73050

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Sq. Hospital

CITY OF BALTIMORE: (No. ..... ST., 21 WARD)

2-FULL NAME Walter Johnson

(a) RESIDENCE NO. 536 W. Cross ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19-1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	14	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Robt Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maud Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maud Johnson (Address) 536 W. Cross St

15 Filed FEB 27 1923 19... ROBERT P. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25- 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec-15-, 1922, to Feb-25, 1923, that I last saw him alive on Feb-25, 1923, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows: Appendicitis (Suppurative)

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) ... yrs. ... mos. 30 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of 12-15-22

Was there an autopsy? No

What test confirmed diagnosis? Op. Findings

(Signed) Newton D Parr, M. D.

2/25, 1923 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Feb 28 1923

20 UNDERTAKER John H. Jordan — ADDRESS 142 Uhler St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73051

CERTIFICATE OF DEATH.

11-002 D73051

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 Ridgely ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Rose

(a) RESIDENCE NO. 928 Ridgely ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND~~ of (or) ~~Wife~~ of Robert H. Rose

6 DATE OF BIRTH (month, day, and year) aug. 30, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Worcester Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER John Townsend

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Thornton

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Mary Belt
(Address) 925 Ridgely St.

15 Dec'd FEB 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Feb 26, 1923, that I last saw h[illegible] alive on Feb 20, 1923, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Crenshaw, M. D.

Feb 27, 1923 (Address) 517 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cemetery DATE OF BURIAL Feb 28 1923

20 UNDERTAKER Margaret A. Flynn ADDRESS 1722 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D73052

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

D73052

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Frank F. MacTindall

(a) Residence No. 1401 Harford St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 3 1904

7-AGE, 19 yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Independent Oil Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Fielder Macandale

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Margaret Wolfe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mr. Fielder Macandale

(Address) 1401 Harford Ave

15- Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 25-23

17- I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1923 to Feb. 25 1923

that I last saw h.. alive on Feb. 25th 1923

and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

1a-Lobar Pneumonia

.....(Duration).....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary) 1b-Lobar Pneumonia Empy. Abscess Left Side

.....(Duration).....yrs.....mos. 21 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? yes Date of Jan 25-23

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Jamie Jas Gunn M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery — DATE OF BURIAL. February 28, 1923

20-UNDERTAKER. Henry Hoech Sons — ADDRESS 1301 E Lafayette

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73053

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

D73053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 E Chase ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget A. Owings

(a) RESIDENCE NO. 1208 E Chase ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? 67 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Henry A. Owings

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER M. Hagerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr Henry A Owings

(Address) 1208 E Chase

15 FEB 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26 1923

17

I HEREBY CERTIFY, That I attended deceased from February 20, 1923, to Feby 26, 1923, that I last saw her alive on Feby 25, 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Lagrippe and Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Duplication

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hyman Whitbeck, M. D.

2-26-1923 (Address) 1618 Goodrich Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Joseph's Cemetery Texas Md	Feb. 28 1923
20 UNDERTAKER	ADDRESS
Henry Hooch Son	1301 E Eager

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73054

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D73054

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 712 N. Gay St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred L. Hopkins

(Residence in Baltimore: No. 712 N.Gay St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write Word.)
female	white	Single

6-DATE OF BIRTH. Sept. 1/18 (Month) (Day) (Year) 1.....

7-AGE. 4 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Michael T. hopkins

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Helen M. Watson

13-BIRTHPLACE OF MOTHER, (State or Country). Balto .Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M.T.Hopkins

(Address) 712 N.Gay

15- FEB 27 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit 6[illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 26/23 (Month) (Day) (Year) 192.....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- 2nd degree burns over abdomen and lower extremities. Kettle of hot water spilled on herself by herself

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Wallen M. D. (Coroner.)

2/27/23 (Address) 503 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cemetery Baltimore	March 1 192[illegible]

20-UNDERTAKER.	ADDRESS.
Henry Storck & Son	1301 E Eager St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73055

CERTIFICATE OF DEATH.

185 ✓ D73055

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Greenway Apartments ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A. Knight.

(a) RESIDENCE NO. Charles & 34th. St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, ~~or Divorced, (write the word)~~
F.	W.	Widowed.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of G. Harvey Knight.

6 DATE OF BIRTH (month, day, and year) Nov 7th, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Brunswick
(State or country) N. J.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs A. Thompson Dukes
(Address) Greenway Apts.

15 FILED FEB 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26th, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21st, 1923, to Feb. 26th, 1923, that I last saw her alive on Feb. 25th, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary oedema.

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture of neck of femur

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Application of cast Date of ...

Was there an autopsy? No

What test confirmed diagnosis? X-ray of hip, palpation and auscultation for chest complications.

(Signed) Wm E. Bennett, M. D.

2-27 1923 (Address) 4 E. Madison St., Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden New Jersey.

DATE OF BURIAL Feb 27 1923

20 UNDERTAKER Bertram L. Cole

ADDRESS 123 N. Eutaw St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fracture caused by fall while walking in her room.
Accident

Spec.—1-10-21—M&T—1500 Blks.

D73056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D73056

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2711 Huntington Ave (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Jesse & Sarah Webster

(a) RESIDENCE NO. 2711 Huntington Ave (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 26 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1 hr.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 600

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto County

PARENTS

10 NAME OF FATHER Jesse Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jesse Webster

(Address) 2711 Huntington Ave

15 FEB 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1923, to Feb. 26, 1923.

that I last saw him alive on Feb. 26, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mo.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature separation of placenta (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Smachin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Feb 27, 23

20 UNDERTAKER Ehenowelth Son ADDRESS Chestnut Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73057

CERTIFICATE OF DEATH.

8 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 N Broadway ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Elizabeth Teal

(a) RESIDENCE NO. 1230 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Washington Teal

6 DATE OF BIRTH (month, day, and year) Mch 31 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	69	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER James Bowie

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Kezia Elliott

13 BIRTHPLACE OF MOTHER (city or town) Elliott Island Md
(State or country)

14 Informant Mrs. Laura V. McArthur
(Address) 1230 N. Broadway

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb - 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb - 21, 1923, to Feb - 25, 1923, that I last saw her alive on Feb - 24, 1923, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: —

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E. Gill Hall, M. D.

Feb 28 1923 (Address) 1617 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Feb 28 1923

20 UNDERTAKER Jno B Spence — ADDRESS 1325 N Caroline St

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73058

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73058

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 52 S. Fulton ave ST. 19 WARD)

2-FULL NAME William Schreiber

(a) RESIDENCE NO. 52 S. Fulton ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schreiber

6 DATE OF BIRTH (month, day, and year) Feb 21, 18

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
83		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Henry Schreiber

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Miss Carrie Schreiber
(Address) 52 S Fulton ave

15 FEB 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 26, 1923, that I last saw him alive on Feb 26, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) chronic interstitial nephritis

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Walter A Cot M. D.

2/27, 1923 (Address) 543 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 1 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D73059

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Bruce ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel A. Kennard.

(a) RESIDENCE NO. 1630 Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Kennard

6 DATE OF BIRTH (month, day, and year) May 2 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of Industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cirey Ponsell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Carrie Kennard (Address) 1630 Bruce St.

15 Filed FEB 7 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Stark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1923, to Feb 25, 1923, that I last saw h[er] alive on Feb 23, 1923, and that death occurred, on the date stated above, at One A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) — yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis. Indefinate.

— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Clarke, M. D.

Feb 26 1923 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 3/1 1923

20 UNDERTAKER James H. Davis — ADDRESS 1313 Greenmount

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73060

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 N. Calhoun ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Evans Gray

(a) RESIDENCE. No. 1331 N. Calhoun ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J. Gray.

6 DATE OF BIRTH (month, day, and year) Jan 8 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Smithville
(State or country) Calvert County, Md.

PARENTS

10 NAME OF FATHER Richard Emory Evans.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Ann Griffith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co. Md.

14 Informant Gertrude Evans
(Address) 1331 Calhoun St.

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25 1923

17 I HEREBY CERTIFY, That I attended deceased from January 13, 1923, to Feb 25, 1923
that I last saw h alive on February 23, 1923
and that death occurred, on the date stated above, at 4.30 A.m.
The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic
(duration) yrs. 4? mos. ds.

CONTRIBUTORY (Secondary) Age. Arterio Sclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hyaline Casts

(Signed) William H. Wright M. D.

(Address) 1204 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	2/27 1923
20 UNDERTAKER Miller & Dennis	ADDRESS 303 Gilmor

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rls.

D73061
161724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131 D73061

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Lola Ford

(a) RESIDENCE No. 1151 N. Mount St. City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 31, 1922

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Ford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Blanche Brown

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1923 to Feb. 25, 1923, that I last saw her alive on February 25, 1923, and that death occurred, on the date stated above at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Acute pyelo-nephritis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Primary —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X

(Signed) A. A. Weed, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pvt. Cyprus	Feb 28 1923
20 UNDERTAKER James R. Lamond	ADDRESS, 313 Gaston

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See instructions on back of certificates. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73062

D73062

CERTIFICATE OF DEATH.

X 73

9

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Brown

(a) RESIDENCE. No. Merry Point, Va. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record
(Address) St. Joseph's Hospital

15 Filed FEB 27 1923

ROBERT P. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1923, to Feb. 25, 1923, that I last saw h C/R alive on Feb. 25, 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Tumor Spinal Cord
(? Dorsal region)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. W.S. - X ray.

(Signed) J. K. Bogenhein, M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Merry Point Va	2/27 1923

20 UNDERTAKER Chas. P. Crane & Son ADDRESS 1180 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73063 HEALTH DEPARTMENT—CITY OF BALTIMORE D73063

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Pennsylvania Ave ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Doe

(a) RESIDENCE NO. 1609 Pennsylvania Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs John Doe

6 DATE OF BIRTH (month, day, and year) Unknown 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpet Weaver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hickory Grove A. A. Co. Md

PARENTS

10 NAME OF FATHER Geo Hezekiah Dow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Margaret Dow (Address) 1609 Penna Ave

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24-1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 —, 1923, to Feb 24, 1923,

that I last saw him alive on Feb. 23—, 1923,

and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Interstitial of Lung

Independent

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. H. Carey M. D.

2-25 1923 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	2/27 1923
20 UNDERTAKER Samuel T Hemsley	ADDRESS 578 N Bridle

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Green Walker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73064

CERTIFICATE OF DEATH.

187-007

D73064

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gorun Walker

(Residence in Baltimore: No. 1348 - Fairmount St. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, ... 1.....
(Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country) South Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Walker

(Address) 1348 Fairmount st

FEB 27 1923 Filed ..... 19..

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 24 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures,
(Crushed over body -)
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Shocks
(Duration)..... yrs..... mos..... ds.

(Signed) Geo Clifton Platt M. D.
(Coroner.)

2-26 1923 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cmty — DATE OF BURIAL, March 1 1923

20-UNDERTAKER, George H Holland — ADDRESS 1631 Druid Hill Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Guam Factory

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill*; (*a*) *Salesman,* (*b*) *Grocery*; (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas.*	*Peritonitis.*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—8-24-14—M. & T.—2000 Bks.

Annie D. Mitchell ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73065

74-00 D73065

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Mosher ST.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Mitchell

(Residence in Baltimore: No. 421 Mosher St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... Jan. (Month) 24th (Day), 1861 (Year)

7-AGE.	If LESS than 1 day,
62 yrs. 1 mos. 0 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER, Joshua Mitchell

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Annie Diggs

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Brown (friend)

(Address) 421 Mosher Street

15-

Filed FEB 27 1923, 191.. ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1922, to Feb 24 1923, that I saw h[illegible] alive on Feb 20th 1923, and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Complete Paralysis of left side

..... (Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Feb 25, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Feb. 27, 1923
20-UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Ething St.

PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73066

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73066

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 603 George. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ambrose Williams

(a) RESIDENCE NO. 603 George ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Williams

6 DATE OF BIRTH (month, day, and year) Nov. 3 - 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	34	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor Janitress

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer Lincoln Lodge Lex. B

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chas Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Annie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Herbert L. Williams

(Address) 629 Pearl Street

15 Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Feb 25, 1923, that I last saw him alive on Feb 25, 1923, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of — —

Was there an autopsy? No — —

What test confirmed diagnosis? Clinical

(Signed) I B Tennyson, M. D.

4/21-1923 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb. 28 1923

20 UNDERTAKER Jos. M. Johnson

ADDRESS 234 Ethington St.

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73067

CERTIFICATE OF DEATH.

91-002 V

D73067

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 879 Greenmount Av. St.; 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Fahey

(Residence in Baltimore: No. 879 Greenmount Av. St.; 50 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. 22, 1855
(Month) (Day) (Year)

7-AGE 67 yrs. 2 mos. 2 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER James Fahey

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary B. Fahey

(Address) 879 Greenmount Av.

15- Filed FEB 27 1923 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE ~~OF DEATH~~, February 27, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I ~~attended~~ deceased from Feb. 2, 1923 to Feb. 25 1923, that I saw him alive on Feb. 23 1923, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

1. Uremia - Chronic

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Dil. of Heart

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) E. J. Myers M. D.

2.26.23 191... (Address) 801 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Feb. 28, 191 3
20-UNDERTAKER	**ADDRESS**
H. C. Wiedefeld	914 Greenmount Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73068

D73068

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 936 W. Franklin St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marilda J. E. Henning

(Residence in Baltimore: No. 936 W. Franklin St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: March 22 (Month) (Day) 1853 (Year)

7-AGE: 69 yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Duties
(b) General nature of Industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): England

PARENTS.

10-NAME OF FATHER, John F. Lusby

11-BIRTHPLACE OF FATHER, (State or Country), England

12-MAIDEN NAME OF MOTHER, Annie Henning

13-BIRTHPLACE OF MOTHER, (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gladys E. Henning

(Address) 936 W. Franklin St

15-Filed FEB 27 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 25 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb. 26 1923 (Address) 1802 Eutaw Pl

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

*19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Feb 28 1923
20-UNDERTAKER.	ADDRESS
H. C. Brumingdon	617 N. Schroeder St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73069

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. M. Barry (J. Marshall Barry)

(a) RESIDENCE NO. Academy Hotel ST., Lexington WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Jennie Barry

6 DATE OF BIRTH (month, day, and year) April 4 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	—	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired-merchant

(b) General nature of industry, business, or establishment in which employed (or employer) wholesale Produce Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Wesley Barry

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country) "

12 MAIDEN NAME OF MOTHER Elizabeth Chesley

13 BIRTHPLACE OF MOTHER (city or town) Do not know (State or country) "

14 Informant Mrs Jennie Barry (Address) Academy Hotel, City

15 FEB 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1923

17

I HEREBY CERTIFY, ~~That~~ I attended deceased from Jan 18 1923, to Feb 27 1923, that I last saw him alive on Feb 27 1923, and that death occurred, on the date stated above, at 7.45 Am

The CAUSE OF DEATH* was as follows:

Hypertension - Arterio - Sclerosis - Cardiac Insufficiency - Chr. Nephritis - (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia - Cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/1 1923

20 UNDERTAKER Henry W. Means & Son

ADDRESS 805 N. Calvert St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73070 100-001 D73070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Bank ST., 1 WARD)

2-FULL NAME Joseph Jrzek Irzq Bank

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? 49 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roszalia Jrzek

6 DATE OF BIRTH (month, day, and year) March — 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer (Ind)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Michael Jrzek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Kostancija Liscska.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John N. Jrzak
(Address) #2219 Bank St.

15 FEB 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1923 to Feb 26 1923, that I last saw h— alive on Feb 26 1923 and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilat

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilson W. Good, M. D.

19 (Address) 801 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	March 1-1923.
20 UNDERTAKER M. F. Sadowski,	ADDRESS 705 S Ann St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73071

100-001

CERTIFICATE OF DEATH.

D73071

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1306 E. Pratt ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Feddlerman

(Residence in Baltimore: No. 1306 E. Pratt St.: yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug 18th, 1920 (Month) (Day) (Year)

7-AGE, 2 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or.....mia.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, David Fedderman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ella Silverman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Fedderman

(Address) 1306 E. Pratt St.

15- Filed FEB 27 1923, 191..... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 27th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquify.) thereon and from the evidence obtained by Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) # yrs. # mos. 10 ds.

CONTRIBUTORY (Secondary) ? (Duration) ? yrs. ? mos. ds.

(Signed) Otto M. DeHorton M. D. (Coroner)

Feb 27 1923 (Address) Curtis Bay Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel — DATE OF BURIAL, 1/27, 19 2

20-UNDERTAKER M. Levinson — ADDRESS 1127 Balto St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73072

CERTIFICATE OF DEATH.

90 D73072

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 North Wolfe ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory Leasure

(a) RESIDENCE NO. 813 North Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ... should be stated EXACTLY. PHYSICIANS should state ... form of information ...

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Leasure

6 DATE OF BIRTH (month, day, and year) Aug 14th 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Watertown N.Y.

PARENTS

10 NAME OF FATHER Anthony Leasure

11 BIRTHPLACE OF FATHER (city or town) (State or country) Watertown N.Y.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Anna Leasure

(Address) 813 N Wolfe St.

15 FEB 27 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-25, 1923, to 2-26, 1923, that I last saw him alive on 2-26, 1923, and that death occurred, on the date stated above, at 2.50 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis. General Senility - Arterio-Sclerosis

About (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) H. H. Forget M. D.

, 19 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mar 1923

20 UNDERTAKER Geo M. Frank & Son

ADDRESS 811 N Wolfe

Spec.—1-10-21 M&T 1500 Bks.

D73073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21

D73073

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

2-FULL NAME Anthony Duffy

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	61	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Duffy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Rush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records. (Address)

15 FEB 27 1923 Filed ....., 19..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 21, 19 23, to February 23 19 23.

that I last saw him alive on February 23, 19 23,

and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Erysipelas - facial

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Wickey M. D.

2-24-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL To Philadelphia Pa

DATE OF BURIAL 2/27 1923

20 UNDERTAKER Mrs M. Fink

ADDRESS 1737 W Pratt St

Spec—12-23-21—E.B.P.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73074

CERTIFICATE OF DEATH.

90 D73074

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2437 E. Monument St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Seifert

(a) Residence No. 2437 E. Monument St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., If of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (Write this word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Barbara Seifert

6-DATE OF BIRTH (month, day and year) May 1st 1855

7-AGE. 68 yrs. 10 mos. 4 ds. If LESS than 1 day ....hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labour
(b) General nature of Industry, business, or establishment in which employed (or employer) 040
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Nicholas Seifert

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not Known.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) August Heid

(Address) 2437 E. Monument St

15-Filed FEB 27 1923 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-25-23

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 — 1923 to Feb 25 1923

that I last saw him alive on Feb 24 1923

and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there no autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Brunella M. D

2-26 1923 (Address) 501 N Butler Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer

DATE OF BURIAL. Feb 28 1923

20-UNDERTAKER Jos C. Miller

ADDRESS 2334 Jefferson St

Fill out, sign, and return at once, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D73075

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D73075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 610 N Robinson St. 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred a Bertholdt

(a) Residence No. 610 N Robinson St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Milton Bertholdt

6-DATE OF BIRTH (month, day and year) Feb 27-1902

7-AGE. 20 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John E Gunn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Coleman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-(Informant) Milton Bertholdt

(Address) 2620 E Lafayette ave

15-FILED FEB 27 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Stork.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 25-23

17- I HEREBY CERTIFY, That I attended deceased from Jan. 4 1923 to Feb 25 1923 that I last saw h.. alive on Feb 23 1923 and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Phthisis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Abeacen M. D

2/26 1923 (Address) 1801 Eastern ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL W W Carmel Cem DATE OF BURIAL, Feb 28 1923

20-UNDERTAKER Wm. C. Miller ADDRESS 2334 Jefferson

37

Please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73076

CERTIFICATE OF DEATH.

90 D73076

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 E Preston ST., 8 WARD)

2-FULL NAME Mary Kennedy

(a) RESIDENCE NO. 1612 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 ~~Single, Married, Widowed, or Divorced, (write the word)~~ Widow

~~5a If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John Kennedy

6 DATE OF BIRTH (month, day, and year) May 5 - 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant J. Carroll

(Address) 1612 E. Preston st

15 FEB 27 1925 Filed , 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 19

17 I HEREBY CERTIFY, That I attended deceased from ~~Jan~~ Feb. 25 19 25 to Feb. 25 19 25

that I last saw h~~e~~r alive on Feb. 25 19 25

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Senility — Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Riley M. D.

Feb. 26 19 25 (Address) 1632 Bonner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb. 28 19 25

20 UNDERTAKER Robt J Turner Inc

ADDRESS 1642 E Broadway.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73077

D73077

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Guilford Ave ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Dobbin

(a) RESIDENCE. No. 3003 Guilford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68.	2.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alex. Dobbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Kerins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Kerins.
(Address) 3003 Guilford ave.

15 2/7 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25 1923

17 I HEREBY CERTIFY, That I attended deceased from February 25, 1923, to February 25, 1923, that I last saw h[illegible] alive on February 25, 1923 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Pneumonia,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	2/28 1923
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73078

CERTIFICATE OF DEATH.

161-001 D73078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 W. Hoffman St.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Watts

(Residence in Baltimore: No. 315 W. Hoffman St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH, July 25, 1923
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Wm C. Watts

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Nellie Berman

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. J. Keller

(Address) 2422 W. Lombard St.

15-

Filed Robert F. Harrison

Registrar.

7 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~July 25 1923~~, to ~~July 25~~ 1923, that I saw h alive on after death 191..., and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth
Abt. four months utero-gestation

.... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Not Known

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. J. Keller M. D.

July 25, 1923, (Address) 2422 W. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 191...
20-UNDERTAKER	ADDRESS

Commissioner of Health

Per. Wm. H. Woodall.

FEB 27 1923

0158

important. See instructions on back of certificate.

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73079

CERTIFICATE OF DEATH.

13 D73079

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Moody

(a) RESIDENCE No. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
60	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed FEB 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from January 27, 1923, to February 23 1923, that I last saw him alive on February 23, 1923, and that death occurred, on the date stated above, at 12.0 Noon

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde A. Heuel, M. D.

2-24 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

Per. Wm. S. Woodall, FEB 27 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73080

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-007 D73080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 512 N. Rose St., 7 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Carrie Walker

(a) Residence No. 512 N. Rose St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Walker

6-DATE OF BIRTH (month, day and year) August 6 1867

7-AGE. 56 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer). None

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Fredrech Harron

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bath

12-MAIDEN NAME OF MOTHER. Bridget McCarty

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Erland

14- (Informant) Cathrine Luckhardt

(Address) 430 S. Paterson park

15- Filed 2 7 1923 Robert P. Harrison Registrar.

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) February 26 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 25 — 1923 to Feb 26 1923

that I last saw her alive on Feb 25 1923

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Louis Vogel M. D.

. 19 (Address) 2601 E. Monument.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Feb 28 1923
20-UNDERTAKER	ADDRESS
Wendell Dypelsdon	378 Mm

Dr Louis Vogel

Filed in accordance with the law, and it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important, and CAUSE OF DEATH

Spec—12-23-21—E.B.R.S.—400 Bks.

(Schmelz)

D73081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73081

CERTIFICATE OF DEATH.

122-007

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Schmelz

(a) Residence No. 4085 Mulberry St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Schmelz

6-DATE OF BIRTH (month, day and year) Aug. 1 1864

7-AGE. 58 yrs. 6 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tinner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Fred Schmelz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs Minnie Schmelz
(Address) 4085 N Mulberry

15. Filed 2-7 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 26 23

17- I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1923 to Feb. 26, 1923 that I last saw h[illegible] alive on Feb. 26, 1923 and that death occurred, on the date stated above, at 6 20 p.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver
(Hypertrophic)
(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema
(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical symptoms findings

(Signed) Dr. J. Sedgwick M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Cemetery — DATE OF BURIAL. March 1 1923

20-UNDERTAKER. W. M. Routson — ADDRESS 2238 N Howard

B

27

instructions on back of certificates.

...ified. Exact statement of OCCUPATION is very imp... See

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73082

D73082

CERTIFICATE OF DEATH.

128

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5227 Linden Heights Ave. ST.; 27 WARD)

2-FULL NAME Elizabeth Cynthia Engler

(a) RESIDENCE. NO. 5227 Linden Heights Ave. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. X mos. X ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed or divorced (or) WIFE of John W. Engler.

6 DATE OF BIRTH (month, day, and year) Aug 23. 1842

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or X min.
	80	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer) her home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Liberty Fredk. Co Md.

PARENTS

10 NAME OF FATHER Baltzer Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick - Md.

12 MAIDEN NAME OF MOTHER Lydia Stetely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md.

14 Informant Mrs. A. Schofield

(Address) 5227 Linden Heights Ave

Filed FEB 27 1923 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec ..... 1922 to Feb. 26 ..... 1923, that I last saw h[illegible] alive on Feb. 23 ..... 1923, and that death occurred, on the date stated above, at 3 a. ..... m.

The CAUSE OF DEATH* was as follows:

Acute nephritis superinduced by impaction of age

(duration) 1 yrs. 3 mos. X ds.

CONTRIBUTORY (Secondary) Uremic due to Acute Nephritis (duration) X yrs. X mos. 7 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) P. B. Wilson, M. D.

. 19 (Address) 1124 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mountain Town Md	Feb 28 1923
20 UNDERTAKER W M Routson	ADDRESS 2250 W North

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73083

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534-W. Baner St., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ona Nantes.

(a) RESIDENCE NO. 534-W. Baner St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) 1/29/1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. (W)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Karl Nantes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Ona Lonnstole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Karl Nantes (Address) 534-W. Baner

15 Filed 2 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby. 21, 1923 to Feby 26, 1923

that I last saw h[illegible] alive on Feby 26, 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. C. Spielman M. D.

19 2 (Address) 68 2 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Stanton Cem.	2/28/23.
20 UNDERTAKER	ADDRESS
Geo. J. Puth	1935 Hanford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73084

CERTIFICATE OF DEATH.

74-001 D73084

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Pennington Ave. ST. Curtis Bay 25 WARD)

2-FULL NAME Augustus Henry Webster

(a) RESIDENCE NO. 908 Pennington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lena M. Webster

6 DATE OF BIRTH (month, day, and year) Dec. 27-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist, foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Sulphuric acid works.

(c) Name of employer Davis Chemical Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Joseph Webster

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Rice

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Lena M. Webster

(Address) 908 Pennington Ave.

15 FEB 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1923, to Feb. 26, 1923, that I last saw him alive on Feb. 25, 1923, and that death occurred, on the date stated above, at 1:25 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) Geo Edwards, M. D.

2/26, 1923 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	Febuary 23, 1923.

20 UNDERTAKER Mrs. J.E. Evans & Sons ADDRESS 1438 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73085

CERTIFICATE OF DEATH.

101-001

D73085

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 N. Gilmor ST., 16 WARD)

2-FULL NAME Tillie Thomas

(a) RESIDENCE NO. 1019 N. Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Thomas

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE Years 38 Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Dom

(c) Name of employer Dept

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Eden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daniel Thomas
(Address) 1019 N Gilmor St

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1923

17

I HEREBY CERTIFY, That I attended deceased from ..., 19..., to Feb. 26, 1923,

that I last saw h... alive on Feb. 26, 1923,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James M. Hayes, M. D.

..., 19.. (Address) 1026 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Bal

DATE OF BURIAL 3-2- 1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Ca ave

D73086

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

113 D73086

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 N. Mount St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John Edward Lancaster

(Residence in Baltimore: No. 721 N. Mount St. St., yrs. 3 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Nov. 5 (Month) (Day) 1922 (Year)

7-AGE: ..... yrs. 3 mos. 21 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): boy

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: John Lancaster

11-BIRTHPLACE OF FATHER, (State or Country): Dont Know

12-MAIDEN NAME OF MOTHER: Beanie Cameron

13-BIRTHPLACE OF MOTHER, (State or Country): N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beanie Cameron

(Address) 721 N. Mount St

15-

Filed FEB 28 1923 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 26 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb. 27 1923 (Address) 2303 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn Bur	2-28- 1923
20-UNDERTAKER, Emil Easton	ADDRESS 776 Ba ave

is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73087 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D73087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 74-001

CITY OF BALTIMORE: (No. 431 Druid Hill Ave. WARD 4) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Sabin

(a) RESIDENCE. No. 431 Druid Hill Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Alverta Davis
(Address) 421 Jones St.

15 FEB 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1923, to Feb 24, 1923, that I last saw him alive on Feb 23, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of ...

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bentley Stone, M. D.

2/26 1923 (Address) 1214 Cath. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 2-28 1923

20 UNDERTAKER: Daniel Carbin — ADDRESS: Balto

THIS CERTIFICATE must be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

141667 D73088

HEALTH DEPARTMENT—CITY OF BALTIMORE

41 D73088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. 11 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Maxwell

(a) RESIDENCE No. 736 N. Eutaw St. City ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 23 1920

7 AGE: Years 3 | Months 1 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alex Burrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lizzie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to Feb 26, 1923, that I last saw him alive on February 26, 1923, and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Meplintis (sub-acute)

(duration) yrs. 2½ mos ds.

CONTRIBUTORY (Secondary) Sinusitis - Septicemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine analyses

(Signed) H. H. Wreath, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 3-2-1923

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D73089

1-PLACE OF DEATH University Hospital — REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Wright.

(a) RESIDENCE NO. 796 W. Mulberry st., ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Infant) Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Lathgm

11 BIRTHPLACE OF FATHER (city or town) Kentucky
(State or country)

12 MAIDEN NAME OF MOTHER Viola Wright

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co.
(State or country) Maryland

14 Informant Univ. Hosp. Records
(Address)

15 Filed FEB 28 1923 19.. ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/23.

17 :

I HEREBY CERTIFY, That I attended deceased from 2/24, 1923, to 2/26, 1923, that I last saw her alive on 2/26, 1923, and that death occurred, on the date stated above, at 2:25 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Worcester, M. D.

19, (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Round Bay Md	Feb 28 19 23
20 UNDERTAKER	ADDRESS
Wm H. Harper & Son	Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

D73090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73090

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Garrison

(a) RESIDENCE NO. 832 Raborg St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
27	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Horace Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosie Fitchard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records.

(Address)

FEB 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 17 19 23. to February 25 19 23.

that I last saw him alive on February 25, 19 23,

and that death occurred, on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(Syphilitic) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Clinical etc

(Signed) Clyde McNeil, M. D.

2-26-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Feb 26 23
20 UNDERTAKER	ADDRESS
R. E. Parham	927 Hanlan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73091

CERTIFICATE OF DEATH.

D73091

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE. (No. 5014 Franklin Terrace Ward) 9

2-FULL NAME James Clem Meades

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 5014 Franklin Terrace St.; yrs., 69 mos. 10 ds. 3)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. April (Month) 23 (Day) 1853 (Year)

7-AGE. 69 yrs. 10 mos. 3 ds.

If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Letter Carrier
(b) General nature of Industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel C. Meades

(Address) 5014 Franklin Ter.

FEB 28 1923

Filed ..... 192.

ROBERT R. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 26 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Carter M. D.
(Coroner.)

2/27/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cem DATE OF BURIAL. March 1 1923

20-UNDERTAKER. Wm Tuckner & Sons ADDRESS North & Pa

Is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. So that it

Spec.—1-10-21—M&T—1500 Bks.

D73092

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D73092

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3026 Baker ST. 16 WARD)

2-FULL NAME Alice Elizabeth Chance

(a) RESIDENCE NO. 3026 Baker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Chance

6 DATE OF BIRTH (month, day, and year) Jan 31 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis
(State or country) Md

PARENTS

10 NAME OF FATHER — — Isaac

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Miss Mary Alice Chance
(Address) 3026 Baker St.

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1923 to Feb 26 1923,
that I last saw h er alive on Feb 25 1923,
and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis—
parenchymatous Nephritis: myocarditis
myocarditis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) Walter S Kiblett, M. D.

Feb 27 1923 (Address) 2220 Harrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md — DATE OF BURIAL Feb 28 23

20 UNDERTAKER Wm J Hickey Sons — ADDRESS North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73093

CERTIFICATE OF DEATH.

11-001 D73093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3506 Holmes ave ST. 15 WARD)

2-FULL NAME Mollie Franklin

(a) RESIDENCE NO. 3506 Holmes ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Franklin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Balis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bell Atta

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E Baltimore

15 Filed FEB 28 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19th, 1923, to Feb. 27th, 1923, that I last saw her alive on Feb. 27th, 1923, and that death occurred, on the date stated above, at 8:15 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary): Influenzal

(duration) 8 da. mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Eugene Freund, M. D.

, 19 (Address) 208 N Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Beth. Hebrew Cem

DATE OF BURIAL: 2-28 1923

20 UNDERTAKER: Jack Lewis, 1439 E. Balto

ADDRESS

PHYSICIANS should state exactly the disease or cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73094 HEALTH DEPARTMENT—CITY OF BALTIMORE D73094

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1832 E. Fairmount Ave St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Kellam

(a) RESIDENCE NO. 1832 E. Fairmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Kellman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1439 E. Baltimore St.

15 Filed FEB 28 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1918, to Feb 27th 1923

that I last saw her alive on Feb 26th 1923

and that death occurred, on the date stated above, at 6 10 m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

Arteriosclerosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis? Clinical exam

(Signed) Emmet Jones, M. D.

, 19 (Address) 500 N. Belnord Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holmes Wash. Road	2-28- 19 23
20 UNDERTAKER	ADDRESS
Jost Levis	1439 E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73095

D73095

99-002

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 W. 37 ST., 13 WARD)

2-FULL NAME Samuel E. Webb.

(a) RESIDENCE NO. 920 W. 37 ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula M. Webb.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	79.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. E. Webb (Address) 920 W. 37 St.

15 Filed FEB 28 1923 19... ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923 to Feb. 27, 1923, that I last saw her alive on Feb 27, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion of Both Bronchi

(duration) yrs. 27 mos 3 ds.

CONTRIBUTORY (Secondary) Arteriole Sclerosis

(duration) yrs. 7 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Patient's History

(Signed) Wm E Kelly, M. D.

2-28-23 (Address) 3700 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hamden	Mch 1 1923
20 UNDERTAKER Isenworth & Son.	ADDRESS 347 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Leonard Loveless)

D73096 HEALTH DEPARTMENT—CITY OF BALTIMORE D73096

1-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Mercy Hospital St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Loveless

(a) Residence No. 912 W. 5th St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 28th 1903

7-AGE 19 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stock Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 004
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER Allen Loveless

11-BIRTHPLACE OF FATHER (city or town) Maryland
(State or Country)

12-MAIDEN NAME OF MOTHER Ella Whitehead

13-BIRTHPLACE OF MOTHER (city or town) Maryland
(State or Country)

14-(Informant) Allen Loveless
(Address) 1013 W. 37 St.

15-FILED FEB 28 1929 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 26. 1923

17-I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1923 to Feb. 26, 1923, that I last saw him alive on Feb. 26, 1923, and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Tb of Pneumonia
& Paralytic Stroke

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac fever

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Signs

(Signed) H. Strauss M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem. DATE OF BURIAL. Mar 1, 1923

20-UNDERTAKER. Chenoweth & Son ADDRESS Chestnut Ave

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See that all questions are properly answered.

Spec.—1-10-21—M&T—1500 Blks.

D73097

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D73097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3603 Maple Ave (ST.) 13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ida C Gulden

(a) RESIDENCE NO. 3603 Maple Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 9 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto City Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Flora Gulden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Flora Gulden 3603 Maple Ave

Date FEB 28 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20th, 1923, to Feb 27th 23.

that I last saw her alive on Feb 27th, 1923

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Disease

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Funeral Evidence

(Signed) H. C. Steele M. D.

2/27, 1923 (Address) 1727 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden

DATE OF BURIAL Feb 28, 1923

20 UNDERTAKER Chenowith & Son

ADDRESS Chestnut Ave

TION is very important. See instructions on back of certificates.

...DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73098

CERTIFICATE OF DEATH.

90 ✓ D73098

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary DeMartin

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 07

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 24, 19 23, to February 26 19 23,

that I last saw her alive on February 26, 19 23,

and that death occurred, on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde M. Snell, M. D.

2-27 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sanad Head & Cemy — DATE OF BURIAL Mar 1, 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Monl Av

TION is very important. See instructions on back of certificates.

it may be properly classified. Exact statement of OCCUPA-

DEATH in plain terms, so that

D73099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73099

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward V. Heath

(Residence in Baltimore: No. 2909 Bernard St. St.; yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Married

6-DATE OF BIRTH: Feb 26 (Month) (Day) 1886 (Year)

7-AGE: 37 yrs. 0 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Die setter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Wm F. Heath.

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Hannah Whitlock Weiler

13-BIRTHPLACE OF MOTHER, (State or Country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora C. Heath.

(Address) 2909 Bernard St

15- Filed FEB 28 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb 26 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M.D.

(Address) 1432 N. Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount DATE OF BURIAL, Mar 1 1923

20-UNDERTAKER, Wm Cook ADDRESS 1502 E North

Formerly the property classified. See instructions on back of certificate. Exact statement of OCCUPATION should be important.

Spec.—1-10-21—M&T—1500 Blks.

D73100 HEALTH DEPARTMENT—CITY OF BALTIMORE D73100

CERTIFICATE OF DEATH.

118 600

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Homewood ad ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Frank Weant

(a) RESIDENCE No. 1903 Homewood ad ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie E. Weant

6 DATE OF BIRTH (month, day, and year) July 10 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8.	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Saml. Weant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maggie Delphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C. Roy. Weant

(Address) 1903 Homewood ave

15 FEB 28 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1923, to Feb 27, 1923, that I last saw h/m alive on Feb. 27, 1923, and that death occurred, on the date stated above, at 2.00 p. m.

The CAUSE OF DEATH* was as follows:

Cardio-renal decease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic Illness

(duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Lyman D. abbatt, M. D.

, 19 (Address) 1832 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Mar 1 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Monument

abbatt · 1832 N Caroline St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified. PHYSICIANS should state in plain terms, so that it

Spec.—1-10-21—M&T—1500 Blks.

D73101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73101

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Bercgoy Ave ST., 27 WARD)

2-FULL NAME Annie Wilson Wiseman

(a) RESIDENCE No. 814 Bercgoy Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Wiseman

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John Wiseman (Address) 814 Bercgoy Ave.

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 25th 1923 to Feb 27th 1923, that I last saw her alive on Feb 26th 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical train and train of mine

(Signed) L. L. Gordy M. D.

, 19 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Mar 1 1923
20 UNDERTAKER	ADDRESS
Wm Leork	502 E Monday

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified, so that it

Spec.—1 10-21—M&T—1500 Bks.

D73102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D73102

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1656 Norwood St. 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grover Thompson Sr.

(a) RESIDENCE No. 1656 Norwood ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE (5 Single, Married, Widowed, or Divorced (write the word)) White Widowed

5 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11- 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Grover Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Della Tull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Grover Thompson
(Address) 1656 Norwood ave

15 Filed FEB 28 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1923, to Feb 26, 1923, that I last saw him alive on Feb 26, 1923, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Homer A. Todd, M. D.

2/27 1923 (Address) 735 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Feb 28 1923

20 UNDERTAKER Williams 5015. — ADDRESS 1022 Hall

TION is very important. See Instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. Also the CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73103

CERTIFICATE OF DEATH.

3 1 D73103

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. Carey St. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Blake

(a) RESIDENCE NO. 916 N. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Marred

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Blake

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	43	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife XXXXXXXX

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Moses Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Annie M. Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Morris Blake

(Address) 916 N. Carey St.

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25/ 1923 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 19 23 to Feb 25 19 23.

that I last saw her alive on Feb. 20. 1923, 19

and that death occurred, on the date stated above, at 6. P.M. m.

The CAUSE OF DEATH* was as follows:

Acct. Peritonitis

Tubercular ?

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Unknown Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Feb 28th 19 23

20 UNDERTAKER A. Jones — ADDRESS W. Lexington St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- that it may be properly classified. So

Spec.—1-10-21—M&T—1500 Blks.

D73104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maple & Hickory Ave ST. 27 WARD) (Overlea 100-001)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Greiser

(a) RESIDENCE NO. Maple & Hickory Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Greiser

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Koppelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant George Greiser

(Address) Maple & Hickory Ave

15 FEB 28 1923 ROBERT R. KRAUTER. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923, to Feb 23, 1923, that I last saw her alive on Feb 23, 1923, and that death occurred, on the date stated above, at 4:20 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claude Jones, M. D.

Feb 24, 1923 (Address) 4722 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 2 1923
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Park Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ... be properly classified. ... PHYSICIANS should state ... in plain terms, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73105

CERTIFICATE OF DEATH.

66 ✓ D73105

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2312 Boston ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George G. Mc Lewee

(a) RESIDENCE. No. 2312 Boston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mc Lewee

6 DATE OF BIRTH (month, day, and year) May 24, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer) business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Mc Lewee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Leinna Jordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary Mc Lewee
(Address) 2312 Boston Ste

15 Filed FEB 28 1923 19... ROBERT R. KRAUTER, REGISTER.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2- 1923 to Feb. 24 1923, that I last saw him alive on Feb 24 1923, and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Gastritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Geo Keller, M. D.

2-26 19 23 (Address) 1937 Forest St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Feb. 28 1923
20 UNDERTAKER	ADDRESS
N. Sandler & Sons	1710 Flint St

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Unless the cause of death is properly classified,

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73106

CERTIFICATE OF DEATH.

100-001 D73106

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 9 E. Preston (St.) 11 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette Jones Markell

(a) RESIDENCE. NO. 9 E. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Markell

6 DATE OF BIRTH (month, day, and year) May 11, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	9	15	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Judge J. Thos Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A Co Md

12 MAIDEN NAME OF MOTHER May Gambrill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Markell
(Address) 9 E. Preston St

15 FEB 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923, to Feb 26, 1923, that I last saw h[illegible] alive on Feb 26, 1923, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia
(Fulminating)
(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard M. D.

1923 (Address) 4 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 28 1923

20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St

THIS IS very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state what it may be properly classified.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73107 100-001 D73107

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4221 Belview Ave ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily E. Gough

(a) RESIDENCE. No. 4221 Belview Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Dr. Dixon Gough

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co Md.

12 MAIDEN NAME OF MOTHER: Eliz. J. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary E. Gough
(Address) 4221 Belview Ave

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1923, to Feb 25, 1923, that I last saw her alive on Feb 25, 1923, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia - 2 days.

Naso-pharyngitis (Streptococcus?)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cancer of uterus & cervix

(duration) many yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

(Address) 417 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Feby 28 1923

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D73108

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D73108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6004 Fairmount Ave ST., Grove 27th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Johnson Grove 27th

(a) RESIDENCE NO. 6004 Fairmount Ave ST. Grove WARD 27

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeping

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Adam Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: May Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Edward Johnson

(Address): 6004 Fairmount Ave

15 Filed FEB 28 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923, to Feb 27, 1923, that I last saw h alive on Feb 26, 1923, and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:

Tobes Pneumonia

(duration) x yrs. x mos. 3 ds.

CONTRIBUTORY (Secondary): General debility

(duration) x yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Consolidation of Lung

(Signed) Dr. J. E. Benson, M. D.

(Address) 2010 York Road Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Eaton Shore Md

DATE OF BURIAL: March 2. 1923

20 UNDERTAKER: Robert H Elliott

ADDRESS 1725 Ashland Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified. ... in plain terms, so that it ...

Spec.—1-10-21—M&T—1500 Bks.

D73109 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D73109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 N. Dallas ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Byers

(a) RESIDENCE NO. 1734 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 19 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore

PARENTS

10 NAME OF FATHER Richard Byers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co

12 MAIDEN NAME OF MOTHER Surrenen Tragle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Father Richard Byers

(Address) 1734 N Dallas St

15 FEB 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from February 25 1923 to February 27 1923

that I last saw him alive on February 27 1923

and that death occurred, on the date stated above, at 11.30P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. W. Kennard M. D.

2-28 1923 (Address) 708 Encor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 3. 1923
20 UNDERTAKER Wm Robert & Elliott	ADDRESS 1725 Ashland Av

Sec. 2. Fill out all items carefully and accurately. Every question must be answered. Part statement of Doctor on back of certificates. See instructions on back of certificates. Sec. 3. Burial Permit will not be issued unless this certificate is very important.

Spec.—1-10-21—M&T—1500 Rks.

161746
D73110

HEALTH DEPARTMENT—CITY OF BALTIMORE

9 D73110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.
CITY OF BALTIMORE: (No. 331 E. 23rd St ST., 12 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Beasley

(a) RESIDENCE NO. 331 E. 23rd St Balto City ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20, 1923

7 AGE: Years 1 Months Days 7
If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Theodore Beasley
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Elizabeth Coates
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) ROBERT P. KRAUTER

15 FEB 28 19[illegible] Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 19 23

17
I HEREBY CERTIFY, That I attended deceased from Febuary 17, 1923, to Febuary 27, 1923, that I last saw her alive on Febuary 27, 1923, and that death occurred, on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) A. A. Veech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laural Cemetery — DATE OF BURIAL: March 1, 1923

20 UNDERTAKER: Wm R A Elliott — ADDRESS: 1725 Ashland Ave

FROM is very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state

D73111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D73111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 E. Eager ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore B. Esender

(a) RESIDENCE NO. 833 E Eager ST., 1st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Sing'l.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 10 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Theodore Esender

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Catherine McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mr. Harry Esender

(Address) 833 E. Eager St.

15 Filed FEB 28 1923, 19 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1922, to Feb 26, 1923, that I last saw alive on Feb. 26, 1923, and that death occurred, on the date stated above, at 11 — a. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Feik M. D.

(Address) 933 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: March 1 1923

20 UNDERTAKER: Henry Hooch Son — ADDRESS: 1308 Eager St

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. If it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D73112

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4412 Ready Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Deets

(a) Residence No. 4412 Ready Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~Widowed~~, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Geo. A Deets

6-DATE OF BIRTH (month, day and year) Dec 12, 1845

7-AGE, 77 yrs. 2 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Henry Rhoff

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Margaret Conner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14-(Informant) Thos Deets

(Address) 4412 Ready Ave

15-FEB 28 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feby 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 15, 1921, to Feb. 27, 1923, that I last saw h.. alive on Feb. 27, 1923, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & hypertension

several years.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac decompensation

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted ——— if not at place of death?.....

Did an operation precede death? no Date of ———

Was there an autopsy? no

What test confirmed diagnosis? B. Pressure. Physical Exam.

(Signed) H. E. Wright, M. D.

2/27, 1923 (Address) 728 E. 41st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pleasant View Cem

DATE OF BURIAL, Friday Mar 2, 1923

20-UNDERTAKER, Wm Cook

ADDRESS 501 E Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73113 — 129 — D73113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Boarding House 113 W Biddle) REGISTERED NO.

CITY OF BALTIMORE: (No. ~~112 Bolton~~ St.: 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frances A. Trooper (Harper) (Tropper)

(a) RESIDENCE. No. ~~1112 Bolton~~ St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Thomas Harper

6 DATE OF BIRTH (month, day, and year) Oct. 15th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland Neck N. C.

PARENTS

10 NAME OF FATHER John G. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Hester Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland N. C.

14 Informant Mrs. Frances Jones. (Address) 1136 Myrtle Ave.

15 FILED FEB 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24th, 1923, to Feb. 26th, 1923, that I last saw her alive on Feb. 26th, 1923, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (Arteriosclerosis)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs. mos. 4 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms, Urinalysis

(Signed) Edward Bell, M. D.

19 (Address) 1224 Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 1 1923
20 UNDERTAKER Brown & Tilghman	ADDRESS 1545 Lanvale

Print in very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73114 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D73114

CERTIFICATE OF DEATH. X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 Bolton ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Banks

(a) RESIDENCE. No. 928 Bolton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Banks.

6 DATE OF BIRTH (month, day, and year) 70 by estimation

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer William Spears

9 BIRTHPLACE (city or town) Talbot Co.
(State or country)

PARENTS

10 NAME OF FATHER Jerry Banks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Talbot Co.

12 MAIDEN NAME OF MOTHER Harriet ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Talbot Co.

14 Informant Arthur Coston
(Address) 928 Bolton St.

Filed FEB 28 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from February 19, 1923, to Feb 27, 1923,
that I last saw h alive on Feb 26, 1923,
and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diffuse Nephritis.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Talbot Co.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

(Address) 209 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Talbot Co Md	2/28/23

20 UNDERTAKER Samuel T Hegeday ADDRESS 578 Biddle St

Sec. 4. Penalty for failure to report promptly, classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73115

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Brunt. ST. 17 WARD)

2-FULL NAME Thos Lee Walker

(a) RESIDENCE. No. 1305 Brunt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Warrenton Va
(State or country)

PARENTS

10 NAME OF FATHER Samuel Walker

11 BIRTHPLACE OF FATHER (city or town) Warrenton Va
(State or country)

12 MAIDEN NAME OF MOTHER Cyphy Warner

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Elizabeth Parker
(Address) 1704 Druid Hill ave

15 Filed ..... 19.....

FEB 28 1923

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to Feb 27, 1923,

that I last saw her alive on Feb 27, 1923,

and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) A. L. Hower, M. D.

(Address) 7128 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Warrenton Va	2/27/1923
20 UNDERTAKER Saml T Hawley	ADDRESS 578 Riddle

Exact statement of OCCUPA-

See instructions on back of ce

important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73116 | 129 | D73116

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Washington and 25 Brookline WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hill

(a) RESIDENCE. No. Washington and Brookline ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Hill

6 DATE OF BIRTH (month, day, and year) Feb 20 '18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER August Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Troutman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Hill

(Address) Washington and Brookline

15 FEB 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Feb 26 1923 that I last saw him alive on Feb 26 1923 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Interstitial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

Feb 28, 1923 (Address) 1644 Harlem Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Mch 1 1923
20 UNDERTAKER	ADDRESS
E. Schloman & Son	Hanover St

Important. See instructions on back of certificates.

...ing, or property classified. Exact statement of OCCUPA-...ation is

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D73117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 Grindell ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Brendel

(a) RESIDENCE. No. 211 Grindell ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank L. Brendel

6 DATE OF BIRTH (month, day, and year) July 11th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germy.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Mary Frome
(Address) 211 Grindell st

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feby 27 1923

17 I HEREBY CERTIFY, That I attended deceased from ——, 1904, to Feby 26, 1923, that I last saw her alive on Feby 26, 1923, and that death occurred, on the date stated above, at 315 A m.

The CAUSE OF DEATH* was as follows:

Complication of Diseases - (Heart - Kidneys - Liver)

(duration) 5 yrs. & over mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis? ——

(Signed) Howard D Lewis, M. D.

, 19 (Address) 38 W. 25th st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Feb 28 1923
20 UNDERTAKER	ADDRESS
E Schumacher Son	Hanover

Instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Myocarditis
Could not say patient
had a Bright's Disease
or Cirrhosis of Liver.

Spec.—1-10-21—M&T—1500 Blks.

Julia Lawson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73118

D73118

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Asp ST., 26 WARD)

2-FULL NAME Julia Lawson

(a) RESIDENCE NO. Bay View Asp ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? March

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
55-60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) 1622 McCulloh St

15 FILED FEB 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1920, to Feb 26, 1923

that I last saw her alive on Feb 25, 1923

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil M. D.

2/27, 1923 (Address) Bay View Asp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb 28 1923
20 UNDERTAKER John H. Toad	ADDRESS 142 Lanvale St

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73119

CERTIFICATE OF DEATH.

47 D73119

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1724 McCulloh ST. 14 WARD)

2-FULL NAME George H. Evans

(a) RESIDENCE No. 1724 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ[illegible] 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced (c:) HUSBAND of (c:) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pantry man, Hotel

(b) General nature of industry, business, or establishment in which employed (or employer) At Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant. (Address) Joseph E. Rich, 1724 McCulloh St

15 Filed FEB 28 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16th, 1923, to Feb. 26, 1923; that I last saw h[illegible] alive on Feb. 22nd, 1923, and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows: Cancer of the Liver.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

2/27, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Mch 1 1923
20 UNDERTAKER	ADDRESS 142
John H. Frazier	Ostend St

IMPORTANT. See Instructions on back of certificates. Exact statement of OCCUPATION should state what kind of work is done, and not merely whether laborer, clerk, etc. Cause of death may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73120

CERTIFICATE OF DEATH.

11-001 D73120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2207 E. Eager ST., 7 WARD)

2-FULL NAME Anna Frohn

(a) RESIDENCE NO. 2207 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W-	S- -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER John J. Frohn

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Ernestine Guilbert

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant John Frohn
(Address) 2207 Eager St.

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1923, to Feb 27, 1923, that I last saw h alive on Feb 26, 1923, and that death occurred, on the date stated above, at 6.40 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
probably following La Grippe
(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Phil Augustine, M. D.

19 Address 606 N Patterson Park Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Mar. 1st 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73121

CERTIFICATE OF DEATH.

90 D73121

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 S. Patterson Park Ave ST., 1 WARD)

2-FULL NAME Mary B. Wiley

(a) RESIDENCE NO. 514 S. Patterson Park ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thos. H. Wiley

6 DATE OF BIRTH (month, day, and year) July 24- 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

10 NAME OF FATHER Lamil Nitzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Robert Wiley
(Address) 514 S. Patterson Park ave

15 FEB 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1923, to Feb. 25, 1923, that I last saw her alive on " 24, 1923, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. D. Neer, M. D.

2/27/23 (Address) 408 S Pat Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	March 1 1923
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Lage St.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Every item should be answered

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D73122

D73122

CERTIFICATE OF DEATH.

10/-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hospital 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Arnold

(a) RESIDENCE NO. 1051 1st St. Brooklyn, Md. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Arnold

6 DATE OF BIRTH (month, day, and year) Unknown Nov. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Construction.

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Arnold

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Henrietta Gardner

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hospital Records. (Address)

15 Filed FEB 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1923, to Feb. 27, 1923, that I last saw him alive on Feb. 27, 1923, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Lung Abscess, Right.

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage 3 Mins. (duration)

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) R. M. Rhodes, M. D.

. 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3/1/1923

20 UNDERTAKER E. J. Fanning

ADDRESS 1460 Battery Ave

THIS SPACE is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73123

100-00 D73123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2324 Madison St., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Countess

(a) RESIDENCE NO. 2324 Madison Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. —— mos. —— ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James C. Countess

6 DATE OF BIRTH (month, day, and year): Unknown 1848

7 AGE: Years 75 Months — Days —

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Alex. McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Edgar Countess 2324 Madison ave

15 Filed ..... 19..... Registrar

Burial Permit Clerk

81923

Robert F. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-26-23

17

I HEREBY CERTIFY, That I attended deceased from 2-17-23, 19..... to 2-26-23, 19.....,

that I last saw h[illegible] alive on 2-26-23, 19.....,

and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. mos. ds.,

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical findings, symptoms & course of disease

(Signed) J. Edward Jones, M. D.

2/27, 1923 (Address) 1430 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 3/1 19 23

20 UNDERTAKER: Chas. F. Evans & Son

ADDRESS: 1118 W. Mt. Royal ave

It may be properly classified. Exact statement of OCCUPA-

It is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73124

99-001 D73124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3021 Ann ST., 2 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley Krawczyk

(a) RESIDENCE NO. 3021 Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Krawczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Kamienski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Peter Krawczyk (Address) 302 S Ann St

15 Feb 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to Feb 28, 1923,

that I last saw h— alive on Feb 28, 1923,

and that death occurred, on the date stated above, at 3 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frank B. Thumpson, M. D.

2/28, 1923 (Address) 2431 East

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 1 1923
20 UNDERTAKER	ADDRESS
John McWeber 1803	Bank st

Should be properly classified. Exact statement of OCCUPATION. See instructions on back of certificates. It is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73125

D73125

CERTIFICATE OF DEATH.

14-002 Alsa Ave. Hamilton

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4908 School Ave. ST., 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Hamilton

2-FULL NAME John Greiner

(a) RESIDENCE NO. 4908 School Ave. near Ailsa Ave. ST., WARD Hamilton

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Greiner

6 DATE OF BIRTH (month, day, and year): Oct 29th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alsace France

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Unknown (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown (State or country): Unknown

14 Informant: Victor Greiner (Address) 4908 School Ave.

15 Filed: 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to Feb 27, 1923, that I last saw h[illegible] alive on Feb 27, 1923, and that death occurred, on the date stated above, at 6a. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2/27/1923 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cheboygan Michigan	March 1st 23
20 UNDERTAKER	ADDRESS
Fred W. Lauterbach Sons	Fullerton

Please see that this may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D73126 ✓ D73126

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 Eutaw Ave ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L Sprouse

(a) RESIDENCE. No. 27 Eutaw Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Verge Sprouse

6 DATE OF BIRTH (month, day, and year): May 21 1899

7 AGE — Years: 23. Months: 8. Days: 6. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

8.3.5

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Peter Pryal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Lilly Spruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Verge W Sprouse
(Address) 27 Eutaw Ave.

15 Feb 28 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Feb 27, 1923

that I last saw her alive on Feb. 27, 1923

and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Albert Le Hesser, M. D.

Feb 28 1923 (Address) 1211 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Louse Co Va.

DATE OF BURIAL: Mar. 1923

20 UNDERTAKER: Robt L Turner Inc.

ADDRESS 1442 Broadway

Back of certificates. Exact statement of OCCUPA- ...ions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73127 D73127

CERTIFICATE OF DEATH.

100-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital St. WARD)

2-FULL NAME Roger Williams

(a) RESIDENCE NO. 1428 Jackson St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1906.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Dr

(c) Name of employer Sterling Downey

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Drusilla Hathaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Edward Williams

(Address) 1428 Jackson St.

15 Filed ..... 19 .....

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/23

17 I HEREBY CERTIFY, That I attended deceased from 2/22/23, 19..., to 2/26/23, 19...

that I last saw him alive on 2/26/23, 19...,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia Empyema

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Transcutaneous 2/23/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Tompkins, M. D.

19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	3/1 1923

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1117 Light St

Important. See instructions on back of certificates. Should state exact statement of OCCUPATION, be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73128

CERTIFICATE OF DEATH.

11-001 D73128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto. Hosp. ST. 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Tudor

(a) RESIDENCE NO. 1004 Compton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 9, 19xx

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Walter Tudor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Louise Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Louise Tudor
(Address) 1004 Compton St.

15 Filed Feb 27 1923 Robert P. Harrison
(Burial Permit Clerk) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to Feb 27, 1923, that I last saw her alive on Feb 27, 1923, and that death occurred, on the date stated above, at 11 9. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. X ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John A. O'Connor, M. D.

, 19 (Address) South Balto Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Co.

DATE OF BURIAL Mar. 1 1923

20 UNDERTAKER Margaret G. Flynn

ADDRESS 147 N Eighth St.

See instructions on back. Improperly filled. Exact statement of OCCUPATIONS should be made. Omissions will be properly classified. Exact statement of OCCUPATION on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73129

CERTIFICATE OF DEATH.

161-001 D73129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5502 Cleveland ave ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Premature Birth Baby Crumbling

(a) RESIDENCE. No. 5502 Cleveland ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred \ yrs. \ mos. \ ds. How long in U. S., if of foreign birth? \ yrs. \ mos. \ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, 8 hrs. or ... min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Ray H Crumbling

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wrightsville Pa

12 MAIDEN NAME OF MOTHER Martha E Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland Sims Md

14 Informant Ray H. Crumbling
(Address) 5502 Cleveland ave

15 Filed ..., 19 ...

1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to Feb 28, 1923, that I last saw h[illegible] alive on Feb 28, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Uncertain
Premature Birth 6½ months

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Clinical

(Signed) H. E. Harris, M. D.

2 28 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem	March 1st 1923
20 UNDERTAKER	ADDRESS
John Burns Sons.	Towson Md

Spec.—1-10-21—M&T—1500 Blks.

D73130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73130

11-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107. Conway ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Armsworthy.

(a) RESIDENCE NO. 107. Conway st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63 Jear			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

0.37

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER John.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charle County Md.

12 MAIDEN NAME OF MOTHER H. Jabbe.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles County.

14 Informant H Armsworthy.

(Address) 107 Conway st.

15 1923 Robert P. Harrisdh,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1923, to Dec 26, 1923, that I last saw h alive on Dec 26, 1923, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Sandeman, M. D.

, 19 (Address) 1714 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnum cemtry.	Mard. 1 1923
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford av

Use properly classified. Exact statement of Occupation. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73131

CERTIFICATE OF DEATH.

31 D73131

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Harford ave ST., 9 WARD)

2-FULL NAME Eugene Hargett

(a) RESIDENCE NO. 1704 Harford ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarke Hargett.

6 DATE OF BIRTH (month, day, and year) April 24 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
29.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Groton. Va.

PARENTS

10 NAME OF FATHER John W. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mada Randel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Maria Hargett (Address) 1704 Harford ave.

15 Filed 1923, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 1922 to Feb. 25 1923, that I last saw ~~her~~ alive on Feb. 25 1923 and that death occurred, on the date stated above, at 1.30 A

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. Bruntrack M.D.

+10 23 (Address) 1531 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Port Republic Cemetery. Va.	March 1923
20 UNDERTAKER	ADDRESS
George F. Ruth	1735 Harford ave

If not very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state

Spec.—1-10-21 M&T 1500 Blks.

D73132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73132

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Potz

(a) RESIDENCE NO. 6524 Fate Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
51	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John Potz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Barbara Zelinka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria.

14 Informant Municipal Hospital Records. (Address)

15 Filed Robert P. Harrison, 19 Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1923

17

I HEREBY CERTIFY, That I attended deceased from February 20 1923 to February 26 1923.

that I last saw him alive on February 26 1923.

and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic alcoholism

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Toxic Nephritis (Alcohol) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

2-27-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 2 1923

20 UNDERTAKER Frank X Enochs — ADDRESS 1906 Eastland Ave

Physicians should state properly classified. Exact statement of OCCUPATION on back of certificates. See instructions on back of certificate.

D73133 HEALTH DEPARTMENT—CITY OF BALTIMORE D73133

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Cucchiella

(Residence in Baltimore: No. 2526 E. Eager St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	single

6-DATE OF BIRTH. June 11/21 1.....
(Month) (Day) (Year)

7-AGE. 1 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Billy Cucchiella

11-BIRTHPLACE OF FATHER, (State or Country). Italy

12-MAIDEN NAME OF MOTHER, Florence Vigna

13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Billy Cucchiella

(Address) 2526 E. Eager

15- Filed 1923 Robert P. Harrison,
192
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 28/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of both clinoid processes of sphenoid. (Skull atbase) Accidental fell from chair. Autopsy at hospital ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Pallier M. D.
(Coroner)

2/28/23 (Address) 508 E. North Av

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Mar 1 1923

20-UNDERTAKER,	ADDRESS
Frank Adrack and Son	1906 Ashland av

Please write plainly. Exact statement of OCCUPATION is required. Fill out all items. See other side of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73134

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73134

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 869 W. Lexington St. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Jamison

(a) RESIDENCE NO. 869 W. Lexington St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 1" 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER William J. Jamison

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel A. Reynolds

13 BIRTHPLACE OF MOTHER (city or town) Laurel

(State or country) Md.

14 Informant Miss Kate Jamison

(Address) 869 W. Lexington St.

15 Filed ... 19 ... Registrar

Robert F. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28" 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 19 23, to Feb 28, 19 23,

that I last saw h alive on Feb 28, 19 23,

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Diseases of Heart

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cachexia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Woodward, M. D.

2/28 19 23 (Address) 939 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	March 3" 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

Sec. 1. Property classified. Exact statement of OCCUPATION. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73135

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 W. Lexington St. ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Scrivner

(a) RESIDENCE No. 1416 W. Lexington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wesley Scrivner

6 DATE OF BIRTH (month, day, and year) Oct. 14th 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
60	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Jonathan Brevard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Penn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jesse J. Wyatt

(Address) 1416 W. Lexington St.

15 Filed ....., 19 .....

923 Registrar

Robert F. Garrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27th 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1922 to Feb. 27, 1923

that I last saw h[illegible] alive on Feb. 27, 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy, M. D.

2/28 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mch 2nd 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St

SIDE INSTRUCTIONS ON BACK OF CERTIFICATES. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73136

CERTIFICATE OF DEATH.

23 D73136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1945 W. Lafayette Ave. ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elva Alethia Young

(a) RESIDENCE No. 1945 W. Lafayette Ave. ST.: WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 26" 1884

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
38	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Oliver F. Young

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Elva E. Chance

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant De Lancey B. Young

(Address) 1727 Ashburton St.

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27" 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13" 1923 to Feb 27 1923

that I last saw h[illegible] alive on Feb 26 1923

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) J. B. Coulter Lamar, M. D.

2/27/1923 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 1923

20 UNDERTAKER Joseph B Cook

ADDRESS 1063 N. Eutaw St.

(See instructions on back of certificates. Exact statement of [illegible] required.)

(William C. Bryan) ✓

Spec.—8-24-14—M. & T.—2000 Bks.

D73137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73137

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Brevard ST. 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm C. Bryan

(Residence in Baltimore: No. 1112 Brevard St. Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 22 (Day) 1877 (Year)

7-AGE, 45 yrs. 8 mos. 5 ds. If LESS than 1 day, ... hrs. or .... min ?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance
(b) General nature of industry, business, or establishment in which employed (or employer): Agent 071

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Wesley Bryan

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Emma Durham

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C. Bryan

(Address) 1112 Brevard St.

15- Robert P. Harrison,

Filed ....., 191.....

1423 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 27 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2.23 1923, to 2.27 1923, that I saw h[illegible] alive on 2.27 1923, and that death occurred, on the date stated above, at 10,00 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, in Coma Duration
Lobar Pneum,
Had Influenza, Jan 30th
Jan. (Duration) ..... yrs. ..... mos. 4 ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

2.28., 1923 (Address) 211 N. Lamb[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	3.2., 1923

20-UNDERTAKER Chas. H. Crane & Son ADDRESS 1011 N. Royalton

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73138

D73138

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Butcher

(a) RESIDENCE NO. 1223 Wellwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-27-23

7 AGE	Years	Months	Days	If LESS than 1 day, ~~2~~ hrs. or min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James A. Butcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Marion Bourgeois

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Maryland

14 Informant James A. Butcher (Address) 1223 Wellwood Ave

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-23 19

17 I HEREBY CERTIFY, That I attended deceased from 2-27-23, 19..., to 2-28-23, 19, that I last saw him alive on 2-28-23, 19, and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Moses Polikoff, M.D.

2 mon 3 Falls Rd (Address) Falls Road, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	March 1, 23
20 UNDERTAKER Horace H. Burgee	ADDRESS 563 Fallsway

Important. See instructions on back of certificates. Exact statement of OCC[illegible] should give.

Spec—12-23-21—F.B.R.S.—400 Bks.

D73139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D73139

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 620 S 12th St. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sumatra Whiteman

(a) Residence No. 620 S 12th St. St., 26 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) Married

5a-If ~~married, widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Clement Whiteman

6-DATE OF BIRTH (month, day and year) April 11, 1878

7-AGE. 44 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Indiana

PARENTS.

10-NAME OF FATHER, W H Richmell

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa

12-MAIDEN NAME OF MOTHER, Hannah White

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14-

(Informant) Clement S Whiteman

(Address) 620 S 12th St.

15-

Filed 1923 Robert F. Harrison, 192

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH. Feb 28,

16-DATE OF DEATH (month, day and year) March 1 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1923 to March 1, 1923

that I last saw h. Se alive on Feb. 25, 1923

and that death occurred, on the date stated above, at 8.0. m.

The CAUSE OF DEATH* was as follows:

Post Grippal Bronchitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Dilated heart

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm J McCreary M. D.

March 1. 1923 (Address) 839 S. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Glen Karn, Dark Co. Md.

DATE OF BURIAL, Thursday March 1, 1923

20-UNDERTAKER: Wm Cook

ADDRESS: 501 E. North

Spec.—1-10-21—M&T—1500 Blks.

D73140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73140

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N. Ellwood ST., 7 WARD)

2-FULL NAME Gladdwin Gorman

(a) RESIDENCE No. 616 N. Ellwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 24 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced~~, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm E. Gorman

6 DATE OF BIRTH (month, day, and year) April 4, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Don't Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know.

14 Informant Mrs Florence Schupp
(Address) 616 N. Ellwood Ave.

15 Filed ..... 19 ..... Registrar
Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22nd, 1923, to Feb 28, 1923, that I last saw her alive on Feb 26, 1923, and that death occurred, on the date stated above, at 9.05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 3½ mos. 8 ds.

CONTRIBUTORY (Secondary) acute Nephritis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Mail Sat - 3. 1923

20 UNDERTAKER Wm. Cook — ADDRESS 504 E Monument

Exact statement of CAUSE OF DEATH required. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73141

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2003 Bank St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Pauline Tullenberg

(a) Residence No. 2003 Bank St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE William F. Tullenberg

6-DATE OF BIRTH (month, day and year) Jan 8 - 1854

7-AGE, 69 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Mauf

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Eckhardt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-(Informant) Mrs. G. D. Stuard

(Address) 2003 Bank Street

15-Filed ... 1923

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 26/23

17-I HEREBY CERTIFY, That I attended deceased from Jan. 25 1923 to Feb. 26th 1923

that I last saw h.. alive on Feb. 24th 1923

and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of....

Was there an autopsy? No

What test confirmed diagnosis? Physical and clinical

(Signed) Harry M. Leventhal, M. D.

, 1923 (Address) 2323 Callow Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Edmondson Cem't

DATE OF BURIAL, March 1, 1923

20-UNDERTAKER William Bond

ADDRESS 502 E Madison

Spec—12-23-21—E.B.R.S.—400 Blks.

D73142

HEALTH DEPARTMENT—CITY OF BALTIMORE

155 D73142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1017 E Baltimore st, Registered No.....

City of BALTIMORE: (No. Presby Hosp + Dispensary St. [illegible] Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Metcalfe

(a) Residence No. 1232 W Lafayette ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Dept Manager

(b) General nature of industry, business, or establishment in which employed (or employer). Stewart & Co

(c) Name of employer. [illegible]

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Geo Metcalf.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Margaret Cook.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-(Informant) Mrs Margaret Metcalf.

(Address) 2008 Ramsay St

15-Filed [illegible] 192 Robert P. Harrison, Registrar.

873 23 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jul 27-23

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1923 to Jul 27 1923 that I last saw her alive on Jul 26 1923 and that death occurred, on the date stated above, at 12.30a m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mastoiditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jul 17

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Herbert H Harlan M. D.

19 (Address) 516 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Mem'l DATE OF BURIAL, 1923

20-UNDERTAKER Wm Cook. ADDRESS 502 E Month,

Spec—12-23-21—E.B.R.S.—400 Blks.

D73143

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73143

CERTIFICATE OF DEATH.

X145-007

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Isabel Moore

(a) Residence No. ..... St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 15 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Moore

6-DATE OF BIRTH (month, day and year) Sept 11, 1886

7-AGE. 36 yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, William Ruth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Annie Scott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Hosp. Record

(Address) .....

15- Filed MAR 1 - 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 1 23

17- I HEREBY CERTIFY, That I attended deceased from Feb 26 19 23 to Mar 1, 19 23

that I last saw h.. alive on March 1 1923

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Influenza

.....

.....

.....

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Pregnancy, Fatal

(Duration) ... yrs. ... mos. 19 ds.

Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) D. V. Sturgis M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

18-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. — DATE OF BURIAL, Mar 3 19 23

20-UNDERTAKER, Easton Son — ADDRESS Ellicott City

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Instrumental Delivery

Spec.—1-10-21—M&T—1500 Blks.

D73144

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D73144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 59 Darby St. ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Gordon.

(a) RESIDENCE NO. 59 Darby St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	3.	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city Md

PARENTS

10 NAME OF FATHER: Wm H. Gordon.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lilliam E. Eisenhood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Wm H Gordon.

(Address) 59 Darby St.

15 Filed MAR 1 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13th, 1923, to Feb. 27th, 1923.

that I last saw him alive on Feb 27th, 1923,

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 11 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? at preparation for burial

(Signed) By Denham R. Clarke, M. D.

, 19 (Address) 124 John Rd — Roland Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden.

DATE OF BURIAL: 3/2. 1923

20 UNDERTAKER: Walter Davis

ADDRESS: 3307 Raine St

Instructions on back of certificate must be carefully examined. Exact statement of OCCUPA-

Code.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73145 D73145

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1917 Hoskel St. Ward) 17

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Cole.

(Residence in Baltimore: No. 607 Gouverneur St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1..... (Year)

7-AGE: 46 yrs. ..... mos. ..... ds.

If LESS than 1 day: ....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: domestic
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Robert James

11-BIRTHPLACE OF FATHER, (State or Country): northern ind

12-MAIDEN NAME OF MOTHER: Amie Salter

13-BIRTHPLACE OF MOTHER, (State or Country): md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Todd glenn

(Address) 607 greenmillen st

15-Filed MAR 1-1923 192.....

ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 26 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows.

Wounds of head and body - Hatchet

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. 9 mos. ..... ds.

(Signed) H. Colin Stokes M. D.
(Coroner)

D. of A. (Address) 142 E. Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: mt auburn Cemetery — DATE OF BURIAL: March 9 1923

20-UNDERTAKER: John H Todvin — ADDRESS: 142 N Hill st

Spec.—1-10-21—M&T—1500 Blks.

D73146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D73146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Myrtle Av ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda V. Payne

(a) RESIDENCE No. 1310 Myrtle Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jany 18th 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	18	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing 069

(b) General nature of industry, business, or establishment in which employed (or employer) Sewing

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James H. Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Bertha L. Faust

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Bertha L. Payne (Address) 1310 Myrtle Av

15 Filed MAR 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 24th, 1923, to May 26th, 1923.

that I last saw her alive on May 26th, 1923.

and that death occurred, on the date stated above, at 10:20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) — yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Asthma and Cardiac Neurosis (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination ? Sputum

(Signed) Edward E. Mackenzie, M. D.

May 27, 1923 (Address) 324 W North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	March 2, 1923
20 UNDERTAKER	ADDRESS
John H. Toadvin	142 N. Hill St

Exact statement of OCCUPA-

...tions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Kidwell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73147

CERTIFICATE OF DEATH.

129

REGISTERED NO. D73147

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Druid [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James I Kidwell

(a) RESIDENCE NO. 1617 Druid ST., 21 WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? [illegible] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Kidwell

6 DATE OF BIRTH (month, day, and year) April 24 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James Kidwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Viola Kidwell (Address) 1617 Druid

15 FILED MAR 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Feb 27, 1923, that I last saw h[illegible] alive on Feb 26, 1923, and that death occurred, on the date stated above, at 1400 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Mar 2, 1923 (Address) 507 Leeds

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Mar 1 1923

20 UNDERTAKER Robt F Turner Inc — ADDRESS 1442 N Broadway

(Instructions on back of certificates. Exact statement of OCCUPA-

Now released from Detention Quarantine.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 201 S. Calhoun St.,

CITY OF BALTIMORE: No. 201 S. Calhoun St., ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys May Easton

(a) RESIDENCE. No. 201 S. Calhoun St., ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles A. Easton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie May Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles A. Easton
(Address) 201 Calhoun St

15 MAR 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1923, to Feb 28 1923, that I last saw h[illegible] alive on Feb 27 1923, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

Following Pertussis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Exhaustion Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. McCarter, M. D.

(Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 3/2/23

20 UNDERTAKER: Harry H Withe

ADDRESS: 1531 W Lombard St

D73149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73149

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 417 W. Biddle St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John Davage

(Residence in Baltimore: No. 417 W. Biddle St.; yrs. 59 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH. about (Month) (Day) 1863 (Year)

7-AGE, 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 670

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Davage

(Address) 417 W. Biddle St.

15-

FILED MAR 1-1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 27, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis heart disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) senile cystitis

(Duration) yrs. mos. ds.

(Signed) D. C. Hennessy M. D. (Coroner.)

Feb 28 1923 (Address) 230 Redwood

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Helena Cem	3-1-1923
20-UNDERTAKER.	ADDRESS
Daniel Garber	Pa ave

Wm. Smothers

D73150

100-001

Spec. 6-9-19—H. P. Co.—1000 Blks.

D73150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 St Mary ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Smothers

(a) RESIDENCE. NO. 522 S. Mary ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Smothers

6 DATE OF BIRTH (month, day, and year): July 1 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55	—	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Walter Smothers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Laura Easter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Daniel Easter (Address) 916 Pa ave

15 Filed ....., 19.. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to July 26, 1923

that I last saw him alive on July 25, 1923,

and that death occurred, on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Laura E. Pasmore, M. D.

July 28, 1923 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-1-1923
20 UNDERTAKER Daniel Easter	ADDRESS 916

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73151

CERTIFICATE OF DEATH.

117 D73151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard C. Fonda

(a) RESIDENCE. No. Pikesville, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	9	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Scholar
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country) N.Y.

PARENTS

10 NAME OF FATHER Wm Bayard Fonda

11 BIRTHPLACE OF FATHER (city or town) N. Y.
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Caldwell

13 BIRTHPLACE OF MOTHER (city or town) Phila
(State or country) Pa

14 Informant Mrs Agnes C. Fonda
(Address) 1508 Bolton St

15 MAR 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 12 1923, to Feb. 27, 1923
that I last saw him alive on Feb. 27, 1923
and that death occurred, on the date stated above, at 1105 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency and Sepsis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis following Influenza (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/25/23

Was there an autopsy? No P.S. & S.

What test confirmed diagnosis?

(Signed) E. S. Johnson, M. D.

, 19 (Address) 1212 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa.	Mar 2 1923
20 UNDERTAKER Henry H Jenkins Sons	ADDRESS McCulloh & Eutaw

D73152

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 D73152

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 947 Somerset St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Parker

(Residence in Baltimore: No. 947 Somerset St., 40 yrs., ...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	unknown

6-DATE OF BIRTH. feb 7th 1871
(Month) (Day) (Year)

7-AGE. 52 yrs. ....mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Prescription
(b) General nature of industry, business, or establishment in which employed (or employer): pharmacist

9-BIRTHPLACE, (State or Country). Md.

PARENTS:

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country). "

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rolfe

(Address) 1043 W. Lanvale St.

15- MAR 1-1923 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 27/23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas ASphixiation- Accidental
Coffee pot boile d over and
put out burner under same.
Only one bueneron when found.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Fox (Coroner.) M. D.

3/1/23 1923 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cem. DATE OF BURIAL. March 1st. 1923

20-UNDERTAKER. Geo. J. Ruth ADDRESS 1735 Harford ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73153

D73153

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 S. Fourth St. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonietta Antonio Tibuzzi

(a) RESIDENCE NO. 104 S. Fourth St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ Male

4 COLOR OR RACE White.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER Sabatino Tibuzzi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Maria Vasti

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Sabatina Tibuzzi (Address) 104 S 4th St.

15 Filed MAR 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1923, to Feb 28, 1923, that I last saw him alive on Feb 28, 1923, and that death occurred, on the date stated above, at 3.00 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Maxwell L Mayer M. D.

(Address) 210 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Mch 1 1923.

20 UNDERTAKER Lilly & Zile

ADDRESS 403 S. Wolfe St.

11 3859

...ck of certificates. ...statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D73154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73154

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 S. Chapel St. ST., V WARD)

2-FULL NAME John G. Balk

(a) RESIDENCE NO. 13 S. Chapel St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Balk.

6 DATE OF BIRTH (month, day, and year) Oct. 18-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	38	4.	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 03 V

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Fire Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George C. Balk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elsie Johnson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Balk (Wife)
(Address) 13 S. Chapel St.

15 MAR 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 1922. to Feb 26th 1923. that I last saw him alive on Feb 26th 1923., and that death occurred, on the date stated above, at 5.57 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 1 hour

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bright's Disease

(duration) yrs. 5 mos. 13 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Elijah J. Powell, M. D.

, 19 (Address) 156 W. Mulberry Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	March 1 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 N. Wolfe St.

...ON BACK OF CERTIFICATES. EXACT statement of OCCUPA-...

Spec.—1-10-21—M&T—1500 Bks.

D73155

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 D73155

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 N. Bradford St. 8 WARD)

2-FULL NAME Matilda Buddenbohn

(a) RESIDENCE NO. 1628 N Bradford ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Buddenbohn

6 DATE OF BIRTH (month, day, and year) July 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 03

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Augus Buddenbohn (Address) 1628 N Bradford St.

15 Filed MAR 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1923 to Feb 27 1923

that I last saw h[illegible] alive on Feb 27 1923

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frederick Lanz Reg. M. D.

19 (Address) 710 N Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cem	3/2/23
20 UNDERTAKER	ADDRESS
L. Neumann	321 Broadway

Spec.—1-10-21—M&T—1500 Bks.

D73156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D73156

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3137 Dillon St. ST., 1 WARD)

2-FULL NAME Mahlon Geho

(a) RESIDENCE NO. 3137 Dillon St. ST., 1 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Geho

6 DATE OF BIRTH (month, day, and year) Dec. 22- 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	64	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Statesman 062

(b) General nature of industry, business, or establishment in which employed (or employer) Continental Can

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Ernst Geho.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Wilbur Geho. (Son)

(Address) 3137 Dillon St

15 MAR. 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sep 13 , 1920 , to Feb 27 , 1923 , that I last saw h in alive on Feb 26 , 1923 , and that death occurred, on the date stated above, at 5.00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonic Tuberculosis

(duration) 2 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) W. H. Mahon, M. D.

, 19 (Address) 3015 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	March 2 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 Lanvale St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73157

CERTIFICATE OF DEATH.

162

D73157

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S. 12th St.; No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vivian May Nystrom

(Residence in Baltimore: No. 600 S. 12th St.; —yrs., —mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Jan 30, 1923 (Month) (Day) (Year)

7-AGE, —yrs.—mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Albert Nystrom

11-BIRTHPLACE OF FATHER (State or Country), Finland

12-MAIDEN NAME OF MOTHER Stella May Harris

13-BIRTHPLACE OF MOTHER (State or Country), Hinton, W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Albert Nystrom

(Address) 600 S. 12th St.

15- Filed MAR 1 1923 ROBERT R. KRAUTER, Clerk. Burial Permit Records.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 30 1923, to Feb 28 1923, that I saw h[illegible] alive on Feb 28 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

.....

.....

Acute Nephritis

..... (Duration)....yrs....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration)....yrs....mos.....ds.

(Signed) [illegible] M. D.

Feb 28, 1923. (Address) 3524 Greenmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Schwartz's Cem. DATE OF BURIAL, March, 1923

20-UNDERTAKER Lilly & Zeile ADDRESS 403 N. Wolfe St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73158

CERTIFICATE OF DEATH.

66 V

D73158

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 715 So. First ST. N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Lippert

(Residence in Baltimore: No. 715 So. First St; yrs., mos. dys.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 30th, 1893
(Month) (Day) (Year)

7-AGE. 29 yrs. 3 mos. 27 dys.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk in Saloon
(b) General nature of industry, business, or establishment in which employed (or employer)..... near Bur's down

9-BIRTHPLACE, (State or Country). Balto, Md

PARENTS.

10-NAME OF FATHER. Sebastian Lippert

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Moelter

(Address) 715 So. First St

15-

Filed MAR 1-1923. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 27th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration)..... yrs..... mos..... dys.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... dys.

(Signed) Thos. B. Horton M. D.
(Coroner)

Feb 27th 191... (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Balto, Md

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....dys. In the State.....yrs.....mos.....dys.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Forest Heart Cem. DATE OF BURIAL, March 2, 1923

20-UNDERTAKER Lilly & Zeile ADDRESS 402 S. Wolfe

Spec.—1-10-21 M&T 1500 Blks.

D73159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D73159

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Thomas

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 MAR 1 1923 Filed , 19

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 23, 19 23, to February 28 19 23, that I last saw her alive on February 28, 19 23, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration 30 yrs. mos ds.)

CONTRIBUTORY (Secondary) Cerebro-spinal syphilis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Wassermann etc

(Signed) Clyde M. Reed, M. D.

3-1-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Nestrans Cemetery

DATE OF BURIAL 3/2- 1923

20 UNDERTAKER Thos M. Frank

ADDRESS 1737 W Pratt St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D73160

CERTIFICATE OF DEATH.

38 D73160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 2a WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Robinson

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	---	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed MAR 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 19 23

17 I HEREBY CERTIFY, That I attended deceased from September 25 19 22, to February 27, 19 23, that I last saw him alive on February 27, 19 23, and that death occurred, on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 28 yrs. mos ds.

CONTRIBUTORY (Secondary) General Paresis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. & Ser.

(Signed) Clyde Shreiff M. D.

2-28-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbury Evergreen Cemetery

DATE OF BURIAL 3/3 1923

20 UNDERTAKER Robert E Williams

ADDRESS 1515 McElderry St

...ions on back of certificate. ...exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73161

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 N. Carey St = ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Elvin Cromwell

(a) RESIDENCE. No. 430 N. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie L. Cromwell

6 DATE OF BIRTH (month, day, and year) June 5. 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Levi Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) a a Co Md

12 MAIDEN NAME OF MOTHER Margaret Sutzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Nellie H. Cromwell 430 N. Carey St

15 MAR 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 1923 to Feb 27 1923, that I last saw him alive on Feb 26 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas L Hooper, M. D.

19 (Address) 3463 28.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Mch 1 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St.

Spec.—1-10-21—M&T—1500 Blks.

D73162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73162

REGISTERED NO.....

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 2109 McCulloh ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gracie Jones

(a) RESIDENCE NO. 2109 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Jones

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years 62 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Capitol Co Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Henry Johnson

(Address) 1313 Hoadley St

15 MAR 1-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1923. to Feb. 27, 1923.

that I last saw her alive on Feb. 26, 1923,

and that death occurred, on the date stated above, at 5 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis (Interstitial)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

(Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dennis Sta. Capitol Co

DATE OF BURIAL Mar 3 1923

20 UNDERTAKER James H. Dennis

ADDRESS 303 Preston

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73163

CERTIFICATE OF DEATH.

31 D73163

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ned Rambert

(a) RESIDENCE No. 728 pennsylvania ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER William Rambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Rena Boykin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) M.T.H.

15 Filed MAR 1-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1922, to Feb. 25, 1923, that I last saw him alive on Feb. 25, 1923, and that death occurred, on the date stated above, at 10.20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Balaglucca, M. D.

2-26-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 3/1, 1923

20 UNDERTAKER Francis H. Davis — ADDRESS 203 Freshman

...ATE OF OCCUPA-
...ment of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73164

CERTIFICATE OF DEATH.

74-001 D73164

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2541 W. North Ave ST. 15 WARD)

2-FULL NAME. Bakke Reik

(a) RESIDENCE. No. 2541 W. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Jacob Reik

6 DATE OF BIRTH (month, day, and year): June 6 1849

7 AGE — Years: 73 Months: 9 Days: 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo. F. Walther

(Address) 40 S Carrollton ave.

15 MAR 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1923, to Feb 28, 1923, that I last saw h.. alive on Feb 27, 1923, and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage -
(Hemiplegia)

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm S Love, M. D.

Feb 28, 1923 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	March 2 1923
20 UNDERTAKER: Robert S. Lillo	ADDRESS: 2700 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73165 D73165

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 S. Durham ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Stepney

(a) RESIDENCE. NO. 230 S. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19- 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Groceries

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Victoria Blake
(Address) 232 S. Durham

Filed . 19

Registrar

MAR 1-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 19 23, to Feb 27, 19 23, that I last saw h[illegible] alive on Feb 27, 19 23, and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Clyde Burns, M. D.

2-28. 19 23 (Address) 2282 Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	March 2 1923
20 UNDERTAKER	ADDRESS 1302 E Monument
John E Henderson	

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73166

CERTIFICATE OF DEATH.

23 D73166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1933 Hedt ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Tylisz

(a) RESIDENCE NO. 1933 Hedt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 25. 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Stowa Tylisz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Maggie Krzyzowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant M. F. Sadowski for Thomas Tylisz

(Address) 1905 Aisquith St.

Filed ..... 19 ..... Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1923, to Feb 28, 1923.

that I last saw h[illegible] alive on Feb. 28, 1923,

and that death occurred, on the date stated above, at 1015A m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) ... yrs. ... mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Krawek M. D.

Feb 28 '23 (Address) 801 S Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem

DATE OF BURIAL Mar 2. 1923.

20 UNDERTAKER M. F. Sadowski's

ADDRESS 1905 S. Aisquith

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73167

CERTIFICATE OF DEATH.

74-001 D73167

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Essex ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Golombowski

(a) RESIDENCE NO. 2210 Essex St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Golombowsky

6 DATE OF BIRTH (month, day, and year) Nov. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant M. F. Sadowski

(Address) 905 S. Ann St.

15 Filed ....., 19.... ROBERT R. KRAUTER. Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to Feb. 28, 1923,

that I last saw her alive on Feb. 27, 1923

and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Coma

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. P. Neer, M. D.

2/28/23 (Address) 408 E. Pat Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
H. Stanislaus Cem.	Mar 3, 1923.
20 UNDERTAKER	**ADDRESS**
M. F. Sadowski.	905 S. Ann

EXACT statement of OCCUPATION on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73168

CERTIFICATE OF DEATH.

101-001 D73168

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Arlington Ave ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Stapleton

(a) RESIDENCE. NO. 120 S. Arlington Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Stapleton.

6 DATE OF BIRTH (month, day, and year) unknown 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER John Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Stapleton

(Address) 120 S. Arlington Ave.

15 Filed ...19 1-1923 ROBERT R. KRAUSER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1923, to Feb. 27, 1923, that I last saw h[illegible] alive on Feb. 22, 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) J. L. Evans, M. D.

, 19 (Address) 104 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem	May 2 1923
20 UNDERTAKER John Cowan & Son	ADDRESS
Per Frank J Cowan	901 Hollins St

Statement of OCCUPA-

Books of Certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73169

CERTIFICATE OF DEATH.

100-001

D73169

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. Calverton Rd St. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Mary Eulo

(a) RESIDENCE. NO. 19 S. Calverton Rd St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-11-1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Gabriel Eulo

11 BIRTHPLACE OF FATHER (city or town) Hackensack
(State or country) N. J.

12 MAIDEN NAME OF MOTHER Florence Eva McClean

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Chester Ruland, husband
(Address) 2552 Edmondson Ave.

15 SEPT 9 1923 19.... ROBERT H. KRAUSE, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-25-, 1923, to 2-28-, 1923, that I last saw h.r alive on 2-27-, 1923, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) — yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) ... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Ruland, M. D.

2-28, 1923 (Address) 2552 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar 2nd 1923
20 UNDERTAKER	ADDRESS
John F. Howard & Son, Chas F. Howard	90 Holliday St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73170

CERTIFICATE OF DEATH.

135 D73170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 Warren Ave. ST. 24 WARD)

2-FULL NAME John M. Lawrence

(a) RESIDENCE NO. 335 Warren Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah E. Lawrence

6 DATE OF BIRTH (month, day, and year) Jany. 15 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dan'l H. Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. Sarah E. Lawrence

(Address) 335 Warren Ave.

Filed 1923, 19 ROBERT P. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 19 23

17

I HEREBY CERTIFY, That I attended deceased from Jany, 19..., to Feb 28, 19 23,

that I last saw h[illegible] alive on Feb 28, 19 23,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Enlargement of Prostate Gland

Uraemia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hammond, M. D.

, 19 (Address) 1350 Ky Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/2 1923

20 UNDERTAKER J. Few McCully

ADDRESS 130 E. Fort.

D73171 HEALTH DEPARTMENT—CITY OF BALTIMORE 89 D73171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1441 Light Street. St., 24 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret J. Anderson.

(Residence in Baltimore: No. 1441 Light Street. St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	White.	Married.

6-DATE OF BIRTH. August 23rd, 1864. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
58 yrs. 6 mos. 4. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER. Levin W. Todd.

11-BIRTHPLACE OF FATHER, (State or Country). Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER. Elizabeth P. Woolford.

13-BIRTHPLACE OF MOTHER, (State or Country). Dorchester Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward B. Anderson (husband)

(Address) 1441 Light Street.

Filed MAR 1-1923 19.. ROBERT R. KRAUTER, Clerical Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 27, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

Obstruction of Coronary arteries.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

March 1, 1923. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	3/2 19 23
20-UNDERTAKER.	ADDRESS
J. F. McCully	130 E. Fort

Spec.—1-10-21 M&P 1500 Blks.

D73172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3820 73172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospi ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Pailca

(a) RESIDENCE NO. 145 W. West st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Joseph Pailca

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Famie Pullem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

Informant Hospital Records

(Address) U. T. H.

Filed 3-1-1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1922, to Feb. 27, 1923,

that I last saw him alive on Feb. 27, 1923,

and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 ? yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Delaglucia, M. D.

2-27-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem — DATE OF BURIAL 3/2 1923

20 UNDERTAKER J. F. McCully — ADDRESS 130 E. Fayette St

Spec.—1-10-21—M&T—1500 Blks.

D73173 HEALTH DEPARTMENT—CITY OF BALTIMORE D73173

CERTIFICATE OF DEATH. X 124

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Hoyt

(a) RESIDENCE NO. Walkerville, W. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 days. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Viola Hoyt ?

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 65 Months 4 Days - If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ticket Agent

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W. Va

PARENTS

10 NAME OF FATHER Frank Hoyt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant (Address) JOHNS HOPKINS HOSPITAL.

Filed APR 1 - 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 1 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923, to March 1, 1923

that I last saw h[illegible] alive on March 1, 1923,

and that death occurred, on the date stated above, at 2 10/60 m.

The CAUSE OF DEATH* was as follows:

Peritonitis, Progressive

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Acute cholecystitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? Yes Date of Feb 27 '23

Was there an autopsy? No diagnosis by Gall Bladder

What test confirmed diagnosis? Culture

(Signed) Warfield M Firor, M. D.

, 19 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Raven Ward West Va

DATE OF BURIAL: March 1923

20 UNDERTAKER: Joseph Abrens

ADDRESS: 2214 Eutaw

Spec.—6-9-13—H. P. Co.—1000 Blks.

D73174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D73174

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Parker

(a) RESIDENCE. NO. University Hospital ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 20, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 22 hrs. or 55 min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Parker

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Snowden

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co
(State or country) Maryland

Informant ...
(Address) Hospital Records

MAR 1-1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Feb 22, 1923, that I last saw h/m alive on Feb 22, 1923, and that death occurred, on the date stated above, at 3 55 A m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY ...
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) J. Norwood Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Destroyed by Cremation	19
20 UNDERTAKER	ADDRESS

D73175 HEALTH DEPARTMENT—CITY OF BALTIMORE 29 D73175

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital 3 St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zinove Zagoivetz.

(Residence in Baltimore: No. 1044 Gramby Street. St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Married

6-DATE OF BIRTH. Do not know. ....., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
35 yrs. -- mos. --- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Dish washer at
(b) General nature of Industry, business, or establishment in which employed (or employer). Hotel Belvedere.

9-BIRTHPLACE, (State or Country). Russia.

PARENTS.

10-NAME OF FATHER. David Zagoivetz.

11-BIRTHPLACE OF FATHER, (State or Country). Russia.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isadore Boiko.

(Address) 1044 Gramby Street.

Filed MAR 1-1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 28, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus.
Accidentally shot in the finger by toy pistol.

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto K. Reinhardt M. D. (Coroner)

March 1, 192 8. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1044 Gramby St. February 22nd. 1923.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus DATE OF BURIAL, March 1, 1923

20-UNDERTAKER. John Grebliauckas ADDRESS 425 S. Paca St.

Spec—12-23-21—E.B.P.S.—400 Eks.

D73176 HEALTH DEPARTMENT—CITY OF BALTIMORE X 99-001 D73176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1640 N. Balto St., 19 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mabel Kimes

(a) Residence No. 1640 N Balto St., Ward. Florida
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 4, 1920

7-AGE. 2 yrs. 2 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Florida

PARENTS.

10-NAME OF FATHER. Fred Kimes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Nettie Grafton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14-(Informant) Mrs Nettie Kimes

(Address) 1640 N Balto St

MAR 1-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 28 1923.

17- I HEREBY CERTIFY, That I attended deceased from Feb 14, 1923 to Feb 24, 1923

that I last saw h[illegible] alive on " " 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ac Bronchitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw A Conaghan M. D.

2/28, 1923 (Address) 24 N Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lansdowne Md

DATE OF BURIAL. Feb 10, 1923

20-UNDERTAKER. W M Routson

ADDRESS 2268 N Fulton

Spec.—8-24-14—M. & T.—2000 Bks.

D73177

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D73177

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Harford Av. St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon E. Widmyer

(Residence in Baltimore: No. 1719 Harford Av. St.; 64 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	W	Single

6-DATE OF BIRTH, Feb 28, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), W. S. A. Md.

PARENTS.

10-NAME OF FATHER, Gordon H. Widmyer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Jackisch

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gordon H. Widmyer

(Address) 1719 Harford Ave

MAR 1-1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 27, 1923
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 24 1923, to Feb 27 1923, that I saw him alive on Feb 27 1923, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)....yrs....mos. 3 ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) Lucas Frank M. D.

Feb 28 23, 191.. (Address) 1823 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 3/2/23., 191...

20-UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73178

CERTIFICATE OF DEATH.

17 74-001 D73178

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1316 Argyle Ave, St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calhoun Rogers

(Residence in Baltimore: No. 1316 Argyle Ave St; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Single

6-DATE OF BIRTH, about ..... 184.. (Month) (Day) (Year)

7-AGE, ~~70~~ 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Rectifier
(b) General nature of industry, business, or establishment in which employed (or employer)... attendant

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alex. Rogers

(Address) Brooklyn, N. Y.

MAR 1 1923

Filed ..... 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 26 (Month) (Day) 192.3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ~~inquest~~ (Inquest, autopsy or Inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteio-sclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb. 28 1923 (Address) 780 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, MAR 1 1923

20-UNDERTAKER, Samuel Hemler — ADDRESS 578 N. Biddle

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73179

CERTIFICATE OF DEATH.

100-001 ✓ D73179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Taylor

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
84	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Municipal Hospital Records.
(Address)

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MAR 1-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 19 23

17 I HEREBY CERTIFY, That I attended deceased from February 22 19 23. to February 27. 19 23.

that I last saw her alive on February 27. 19 23.

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Marine, M. D.

2-28-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Mch 3 1923
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1734 Eager

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Todd
735 N. Fulton Ave

D73180

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 D73180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1812 West Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S. Bromwell

(a) Residence No. 1812 West Lanvale St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella H. Bromwell

6-DATE OF BIRTH (month, day and year) Dec-5-

7-AGE. 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (City or town) Queens Town Co
(State or Country)

10-NAME OF FATHER Jacob Bromwell

11-BIRTHPLACE OF FATHER (City or town) Talbot Co Md
(State or Country)

12-MAIDEN NAME OF MOTHER Ellen Sansbury

13-BIRTHPLACE OF MOTHER (City or town) Queens Town Co Md
(State or Country)

(Informant) Jacob Bromwell

(Address) 1812 W. Lanvale

1923 By Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 1-1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 18, 1923, to Feb 28, 1923, that I last saw him alive on Feb 28, 1923 and that death occurred, on the date stated above, at 2.00 a m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Thomas A. Todd, M. D.

3/1, 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	3-2nd 1923
20-UNDERTAKER William Cook	ADDRESS 502 E North Ave

D73181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73181

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2213 Canary Ct ST.: 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Kork

(Residence in Baltimore: No. 2213 Canary Ct St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 11th, 1858 (Month) (Day) (Year)

7-AGE, 64 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Gavikin

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Katie Connors

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Kork

(Address) 2213 Canary Ct

15- Filed 1923, 191.....

Robert P. Harrison,

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 28th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 1 yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary).....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos Bayne Dorton M. D. (Coroner)

March 1st, 1923 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL St Patricks Cemetery

DATE OF BURIAL, 2/3....., 1923

20-UNDERTAKER Wm Cook

ADDRESS 502 E North

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73182

CERTIFICATE OF DEATH.

90 D73182

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1303 N. Ostend ST. 21 WARD)

2-FULL NAME Jennie Hayster

(a) RESIDENCE NO. 1303 N. Ostend ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Hyster

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
41	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) none 037

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER William H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Jennie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

PARENTS

Informant John A. Hyster
(Address) 1303 N. Ostend St.

Filed ..... 19 .....

Robert P. Harrison,
Registrar
Burial Permit Clerk

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27- 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-1- 1923 to Fe 27 1923,

that I last saw her alive on Fe 27 1923,

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of heart

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) High blood pressure

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Bracc, M.D.

19 (Address) 1227 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Mar. 3-1923
20 UNDERTAKER	ADDRESS
Wm. Cook	North & Fremont Aves

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73183

CERTIFICATE OF DEATH.

90 D73183

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 2129 Homewood ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Hughes

(a) RESIDENCE No. 2129 Homewood ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E Hughes

6 DATE OF BIRTH (month, day, and year) May 4 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margt Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Frank Hughes (Address) 2129 Homewood Ave.

15 Filed 1923 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1923 to Feb 28 1923

that I last saw her alive on Feb 25 1923.

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Vascular Heart Disease

(duration) 19 mos. ds.

CONTRIBUTORY (Secondary) Heart failure — Acute (duration) ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonry, M. D.

19 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	March 3 1923
20 UNDERTAKER E A Wiedefeld &	ADDRESS 501 E 22

Spec.—1-10-21—M&T—1500 Bks.

D73184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73184

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 W Pratt ST. 19 WARD)

2-FULL NAME Julius Herman Kaufmann

(a) RESIDENCE NO. 1820 W Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Kauffmann

6 DATE OF BIRTH (month, day, and year) Feb 15 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	—	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

031

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Kauffmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Kauffmann (Address) 1820 W. Pratt St.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923, to Feb 27, 1923, that I last saw him alive on Feb 27, 1923, and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Autopsy

(Signed) [illegible], M. D.

2/28, 1927 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Paul's Cem: Violetteville	March 2-1923
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk: Ave:

Spec.—1-10-21—M&T—1500 Blks.

D73185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73185

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 Ashland Ave. St. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Yancey

(a) RESIDENCE NO. 1742 Ashland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 22, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Wm. M. Yancey

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Esther Addison

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

Informant Esther Addison

(Address) 1742 Ashland Ave

Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-1923

17

I HEREBY CERTIFY, That I attended deceased from 2-26-, 1923, to 2-28-, 1923, that I last saw h[illegible] alive on 2-28-, 1923, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

2-28-1923 (Address) 611-N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: Mch. 2 1923

20 UNDERTAKER: Thos J. G. Locks

ADDRESS: 1302 Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery:* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.--1-10-21--M&T--1500 Bks.

D73186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73186

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1705 Gough ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cummins

(a) RESIDENCE No. 1705 Gough ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer Fireman 130

(b) General nature of industry, business, or establishment in which employed (or employer): School Building

(c) Name of employer: City of Balto

9 BIRTHPLACE (city or town) (State or country): Ireland

10 NAME OF FATHER: Laurance Cummins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Kavanagh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

PARENTS

Informant: Richard Kavanagh

(Address) 1705 Gough

Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 25, 1923, to Feb 27, 1923, that I last saw h[illegible] alive on Feb 27, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

17 days duration

Emphysema

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Emphysema

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Daniel E Fisher, M. D.

19 (Address) 3326 Pat Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL 3/2/1923

20 UNDERTAKER J. A. Moran

ADDRESS 300 E. Baltimore St

Spec—12-23-21—E.B.R.S.—400 Bks.

D73187

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73187

CERTIFICATE OF DEATH.

60-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4 N Wolfe St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Josephina Augustine

(a) Residence No. 4 N Wolfe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George J Augustine

6-DATE OF BIRTH (month, day and year) May 30 1889

7-AGE. 39 yrs. 6 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, John Lindner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Josephina Becker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

(Informant) George J Augustine

(Address) 4 N Wolfe

Filed ... 192... Robert P. Harrison, Registrar.

Per ... Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) February 27 1923

17-I HEREBY CERTIFY, That I attended deceased from Feb 25 1923 to Feb 27 1923, that I last saw h alive on Feb 20 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Goiter

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C Wade M. D.

(Address) 1437 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	March 2, 1923
20-UNDERTAKER.	ADDRESS
Wendell Dypperson	378 N

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73188

CERTIFICATE OF DEATH.

91-00 V. D73188

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 St. Paul ST., 11 WARD)

2-FULL NAME Margaret LeCompte Edmondson

(a) RESIDENCE NO. 904 St. Paul ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. Winder Edmondson

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John P. Hooper

11 BIRTHPLACE OF FATHER (city or town) Dorchester
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary LeCompte

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant Wm. W. Edmondson Jr.
(Address) 704 Gladstone Avenue

1923 Robert P. Harrison,
, 19 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923 to Feb 28, 1923, that I last saw h[illegible] alive on Feb 28, 1923, and that death occurred, on the date stated above, at 5:40 m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteria - Sclerosis

Unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Jas L. Hooper, M. D.

3.1., 1923 (Address) 346 E. 24th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	3/2/ 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

D73189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D73189

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 518 Vincent Alley St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Harris

(Residence in Baltimore: No. 518 Vincent alley St.; yrs. 40. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	colored	widower

6-DATE OF BIRTH, about (Month) (Day) 1865 (Year)

7-AGE, 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. A. Roberts

(Address) 526 Gilmor St

15- 1923 Robert P. Harrison, 191

Burial Permit Clerk. Registrar.

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 17, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Kaufmann M. D. (Coroner.)

Feb. 27 1923 (Address) 2 E Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, 19

20-UNDERTAKER Commissioner of Health.

ADDRESS Mch 1st

Spec.—1-10-21—M&T—1500 Blks.

161840
D73190

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 ✓ D73190

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.....ST., 10 WARD)

2-FULL NAME Baby McArthur

(a) RESIDENCE No. 712 Anson St City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 7-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Arthur McArthur

11 BIRTHPLACE OF FATHER (city or town) D.C.
(State or country)

12 MAIDEN NAME OF MOTHER Pearl Wright

13 BIRTHPLACE OF MOTHER (city or town) N.C.
(State or country)

Informant (Address) JOHNS HOPKINS HOSPITAL, JOHNS HOPKINS HOSPITAL

Filed ..... 19 ..... Robert P. Harrison, Registrar

0163 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22-1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to Feb 23, 1923, that I last saw her alive on Feb 23, 1923, and that death occurred, on the date stated above, at 8 1/2 a.m.

The CAUSE OF DEATH* was as follows:

Syphilis, congenital
Hemorrhagic diathesis.
Intracranial hemorrhage

(duration) 0 yrs. 0 mos. 16 ds.

CONTRIBUTORY (Secondary) Welmbriben

(duration) 0 yrs. 0 mos. 16 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann Reaction +

(Signed) H. H. Mesch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 28 1923

20 UNDERTAKER Commissioner Health.

Per. Wm. E. Woodall

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73191

CERTIFICATE OF DEATH.

31 D73191

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

2-FULL NAME Irene or Rena Quinn

(a) RESIDENCE No. 2500 York Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory work

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

886

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Patrick Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Mary Bannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

Informant: Hospital Records

(Address) M. T. H.

Filed ..... 19 ..... Robert T. Harrison, Registrar
Burial Permit Clerk.

929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to Feb. 28, 1923, that I last saw her alive on Feb. 28, 1923, and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dalaglasca M. D.

2-28-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem.

DATE OF BURIAL: 3/3 1923

UNDERTAKER: Chas. Frazier & Son

ADDRESS: 1180 W. Royalton

Spec—12-23-21—E.B.R.S.—400 Bks.

D73192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73192

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Warrs Home St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Reeves

(a) Residence No. 1400 W Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, Wht | 5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (~~Write the word~~)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 20, 1852

7-AGE, 71 yrs. 1 mos. 19 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Jacksonville Florida

PARENTS.

10-NAME OF FATHER, Job Walter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Hayward Co Maryland

12-MAIDEN NAME OF MOTHER, Ellen Slack

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

(Informant) Mrs J Jones

(Address) 1400 Lexington St Matron

Feb 28, 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 28-23

17- I HEREBY CERTIFY, That I attended deceased from Feb 26, 19 23 to Feb 28, 19 23, that I last saw h... alive on Feb 25, 19 23, and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood M. D.

Feb 1, 19 23 (Address) 1939 W Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park | DATE OF BURIAL, March 2, 1923

20-UNDERTAKER, George J Smith | ADDRESS 1532 Hollins

Spec. 6-9-19 H. P. Co. 1000 10ca.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73193

CERTIFICATE OF DEATH.

11-001 D73193

1-PLACE OF DEATH Baltimore Md.

CITY OF BALTIMORE: (No. 2325 Barclay ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph B. Watson

(a) RESIDENCE NO. 2325 Barclay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~74~~	74	10.	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Drugs.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER James F. Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Md~~ Va.

12 MAIDEN NAME OF MOTHER Mary Scarborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Louise F. Watson
(Address) 2325 Barclay St.

Filed Robert P. Harris
Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Feby 26. 1923, to March 1, 1923, that I last saw him alive on Feby 28, 1923, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) O. W. Ingram, M. D.

, 19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Park	Mar 3 1923
20 UNDERTAKER	ADDRESS
George J. Smith	Hollins 532

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73194

CERTIFICATE OF DEATH.

X 44 D73194

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard & Kelly Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. George A. Cook.

(a) RESIDENCE. No. Winchester Va ST., WARD. Winchester, Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va. Virginia

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

PARENTS

Informant Hospital Record
(Address)

Filed 923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1923, to March 1, 1923, that I last saw h.... alive on March 1, 1923, and that death occurred, on the date stated above, at 4:50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pylorus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post - operative shock (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Winchester, Va.

Did an operation precede death? Yes. Date of Feb. 27, 23

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Robert E. Fridee, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winchester Va	March 2 1923
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W Fayette Ave

Spec.—1-10-21—M&T—1500 Blks.

D73195

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73195

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 W. Conway ST., 22 WARD)

2-FULL NAME Jennie E. Buck

(a) RESIDENCE No. Bowens, Calvert Co, Md ST. ..... WARD Bowens Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred constant visitor How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Randy Buck

6 DATE OF BIRTH (month, day, and year) Sept, 20, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	70	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hutchins

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Williams

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Maryland

Informant Samuel Hutchins

(Address) 128 W. Conway

Filed ....., 19 ..... Robert F. Harrison Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 27 1923

17

I HEREBY CERTIFY, That I attended deceased from 2/22, 1923, to 2/27, 1923.

that I last saw her alive on 2/27, 1923,

and that death occurred, on the date stated above, at 10 50 6, m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Influenza a)

(duration) — yrs. — mos 12 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis + Endocarditis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) David Franchin M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem Calvert Co. Md	3/1 1923
20 UNDERTAKER Robert Burkeam	ADDRESS 1715 Calhoun St

D73196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73196

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1127 Nanticoke St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Helen Barbringer

(Residence in Baltimore: No. 1127 Nanticoke St.; yrs., 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	Married

6-DATE OF BIRTH. July (Month) 14 (Day) 1853 (Year)

7-AGE. 69 yrs. 7 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Johns Gentsch

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Augusta Heller

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Barbringer

(Address) 1127 Nanticoke St

Filed 1923 Robert P. Harrison, 192.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupture Coronary Artery (Duration) Sudden mos. ds.

(Signed) James M. Hinton M. D.
(Coroner.)

Feb 27 1923 (Address) 201 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
WESTERN CEM	MAR 3, 1923

20-UNDERTAKER, ROBERT BROOKS SON

ADDRESS 201 CALHOUN HOLLINS

Spec.—1-10-21—M&T—1500 Bks.

D73197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 57

D73197

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 St Paul ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archibald F. Patterson

(a) RESIDENCE NO. Laurinburg N. C. ST., WARD Laurenburg N. Co

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Emily E. Patterson

6 DATE OF BIRTH (month, day, and year) Jan 1 857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	66	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurinburg N. C.

PARENTS

10 NAME OF FATHER Archibald Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Fairlea

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs M. F. Patterson (Address)

15 Filed ....., 19 ..... Robert F. Harrison, Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Mar 1, 1923, that I last saw him alive on Mar 1, 1923, and that death occurred, on the date stated above, at 2 P M m.

The CAUSE OF DEATH* was as follows:

Diabetes, Mellitus
Broncho-Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Examination

(Signed) Walter A Parker M. D.

, 19 (Address) 900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurinburg N. C.	Mar 1 1923

20 UNDERTAKER Robt Brooks Rm 170 ADDRESS Baltimore

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73198

X31 ✓ D73198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earle Simpson

(a) RESIDENCE NO. England ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 57 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1894.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Thomas Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Annie Pugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant British Consul

(Address) Baltimore, Md.

1923 Robert F. Garrison,

....., 19 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1 1923

17

I HEREBY CERTIFY, That I attended deceased from 1/3, 1923, to 3/1, 1923,

that I last saw h[illegible] alive on 3/1, 1923,

and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? outside

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) From Meadow, M. D.

3/1, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Mch 2, 23
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Bates

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73199

CERTIFICATE OF DEATH.

101-001

D73199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 49 Main St. Hillsdale, St. Md. 28 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura M. Christy

(a) RESIDENCE NO. 49 Main St. Hillsdale, St. Md. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles B. Christy

6 DATE OF BIRTH (month, day, and year) Apr. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Griffith

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Cox

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

Informant Charles B. Christy
(Address) 49 Main St. Hillsdale, Md.

Filed ..... 19 .....
Robert P. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28" 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20 , 1923 , to Feb 28 , 1923.
that I last saw h alive on Feb 27 , 1923,
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S. Tublett M. D.

2/28, 23 (Address) 2220 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 2, 23
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St

Spec—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73200

D73200

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (ST.) (WARD)

2-FULL NAME George Lilly

(a) RESIDENCE NO. 1030 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chair Caner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Blind Asylum 686

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

Informant Martha Hagan

(Address) 1030 Vine St

Filed ....., 19 .....

1923 Registrar

Robert P. Garrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1922, to Febr. 26, 1923.

that I last saw him alive on Febr. 25, 1923,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Lues

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H. H. Forsmith M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 2 1923
20 UNDERTAKER	ADDRESS
Brune & Tuchfarber	Lehnde

Spec.—1-10-21—M&T—1500 Bks.

D73201

HEALTH DEPARTMENT—CITY OF BALTIMORE

160 D73201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3606 Old Frederick Rd. WARD) 170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Elizabeth Gallagher

(a) RESIDENCE No. 3606 Old Frederick Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER E. Stanley Gallagher

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Helen Manning

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

Informant Stanley Gallagher
(Address) 3606 Old Frederick Rd.

Filed , 19

Robert F. Garrison,
Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23 - , 1922 , to Feb - 27 , 1923 , that I last saw her alive on Feb 26 - , 1923 , and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Difficult Dentition

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) E E Burton, M. D.

2/28, 1923 (Address) 301 Eberon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Mar. 2 1923
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 Eight St.

Spec.—1-10-21—M&T—1500 Blks.

D73202

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D73202

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1437 Patapsco ST., 23 WARD)

2-FULL NAME Rudolph J. Schellenberger

(a) RESIDENCE NO. 1437 Patapsco ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susan Schellenberger

6 DATE OF BIRTH (month, day, and year): Sept. 77

7 AGE: Years 45 | Months | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Box-cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: J. M. Raffel 0/5

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: August Schellenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant (Address): Mrs. Susan Schellenberger 1437 Patapsco St.

Filed ....., 19..... Registrar

325 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jul 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from ..... , 19..... to ..... , 19..... ;

that I last saw him alive on ..... , 19..... ;

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Coronal Summons

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac arthrosis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Benjamin Lash, M. D.

(Address) 1520 Hillsborough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	May 1923
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73203

CERTIFICATE OF DEATH.

185 D73203

REGISTERED NO. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp, ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emmanuel Walters,

(Residence in Baltimore: No. 2241 Green St. St.; 7 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH, about, 1877
(Month) (Day) (Year)

7-AGE, 44 yrs. mon. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Tenn.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records

(Address) Md. Gen. Hosp.,

15- Feb 26 1923

Registrar. Robert P. Harrison, for Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said jury (Inquest, Autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Spine

(Duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) acute alcoholism

(Duration) yrs. mos. 1 ds.

(Signed) J. B. Hennessy, M. D.
(Coroner.)

March 1, 1923 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mount City Tenn, DATE OF BURIAL, Mar 1, 1923

20-UNDERTAKER: Harry W. Witzke ADDRESS: 1513 W. Lombard St.

Spec.—1-10-21—M&T—1500 Blks.

161003
D73204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73204

X 135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis H. Darby

(a) RESIDENCE NO. 3909 Liberty Heights ave ST., ... WARD ✓ Hagerstown Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If ~~married, widowed,~~ or divorced (HUSBAND of) (or) WIFE of Rebecca J. Darby

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

10 NAME OF FATHER Upton Darby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Anna E. Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

Informant JOHNS HOPKINS HOSPITAL.

(Address)

Filed ..... , 19 ..... Registrar

328 Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 , 1923 , to Feb 28 , 1923 ,

that I last saw him alive on Feb 28 , 1923 ,

and that death occurred, on the date stated above, at 5-41 A. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? Yes Date of Feb. 12-1923

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Hare, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Hagerstown Md — DATE OF BURIAL Mar 2-23

20 UNDERTAKER Wm L Rickenbaugh — ADDRESS Hagerstown Md

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73205

CERTIFICATE OF DEATH.

74-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Cathedral ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Janney Hull

(a) RESIDENCE. NO. 610 Cathedral ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia B Hull

6 DATE OF BIRTH (month, day, and year) Oct 13/1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Robert Hull

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Hannah Ann James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant J. Harry Hull

(Address) 97 Mulberry St

Robert P. Harrison, Registrar

1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28. 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922, to Feby 28, 1923, that I last saw h[illegible] alive on Feby 28, 1923, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral arterio sclerosis - with thrombosis in vessels.

(duration) 1? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry D. McCarty M. D.

. 19 (Address) 87 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Mch 2 1923
20 UNDERTAKER	ADDRESS
Chas. E. Franck	527 Madison

Spec—12-23-21—E B R.S.—400 Bks.

D73206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73206

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1612 N Broadway St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry C Streib

(a) Residence No. 1612 N Broadway St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Streib

6-DATE OF BIRTH (month, day and year) Sept 30-1845

7-AGE, 77 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Police Sergeant

(b) General nature of industry, business, or establishment in which employed (or employer)..... 161

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

10-NAME OF FATHER, Jacob Streib

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Helen John

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

(Informant) Mary E Streib

(Address) 1612 N Broadway

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-28-1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Feb 28th, 1923, that I last saw him alive on Feb 27th, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1

Did an operation precede death? No Date of 1

Was there an autopsy? No

What test confirmed diagnosis? Chemical + Microscopic

(Signed) August Horn, M. D.

, 19 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Mar 3, 1923.
20-UNDERTAKER.	ADDRESS
Lemcook	502 E Fayette St

Spec—12-23-21—E.B.R.S.—400 Bks.

D73207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73207

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 602 South Paca St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Hewitt

(a) Residence No. 602 South Paca St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widower

5a-If married, widowed, or divorced. HUSBAND of (or) ~~WIFE of~~ unknown

6-DATE OF BIRTH (month, day and year) Aug 1852

7-AGE, 70 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barkeeper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Not Employed 044

9-BIRTHPLACE (city or town) Charleston
(State or Country) S.C.

10-NAME OF FATHER James G. Hewitt

11-BIRTHPLACE OF FATHER (city or town)
(State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Eleanor Shay

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country) England

(Informant) Geo. H. Hewitt

(Address) 778 W. Cross

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feby 27 '23

17- I HEREBY CERTIFY, That I attended deceased from Feby 20, 1923 to Feby 27, 1923

that I last saw him alive on Feby 27, 1923

and that death occurred, on the date stated above, at 8.25 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Previous Illness

(Duration) yrs. mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) [illegible] M. D.

3/1, 1923 (Address) 206 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, 3/2, 1923

20-UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Blks.

D73208 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

74-001 D73208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1503 N. Bethel St 8

CITY OF BALTIMORE: (No. 1503 N. Bethel ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olevia Frances Clarke

(a) RESIDENCE NO. 1503 N. Bethel ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~, ~~HUSBAND~~ of (or) WIFE of John C Clarke

6 DATE OF BIRTH (month, day, and year) Oct 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	80	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Portsmouth Va.

10 NAME OF FATHER Hezekiah Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portsmouth Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Harry E Haynes

(Address) 1503 N Bethel St

MAR 2 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Feb 28, 1923, that I last saw h[illegible] alive on Feb 28, 1923, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C C Brandenburg, M. D.

Mar 1, 1923 (Address) 1540 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 3 1923
20 UNDERTAKER	ADDRESS
Robt. J. Surney Jr	1422 E Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73209

CERTIFICATE OF DEATH.

51 D73209

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 Richmond ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erma Mackell

(a) RESIDENCE. No. 228 Richmond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 26, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Mackell

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Hannie Bean

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Samuel Mackell
(Address) 228 Richmond St.

Filed MAR 2 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1922, to Feby 28, 1923, that I last saw her alive on Feby 27, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

(duration) — yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(duration) — yrs. One mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pettetaan, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	3-3 1923
20 UNDERTAKER	ADDRESS 142
Jno H. Joseph	W. Hoff St

Spec.—1-10-21—M.&T.—1500 Blks.

D73210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D73210

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Leadenhall ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Smith

(a) RESIDENCE No. 809 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) c

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Harry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ida Leatherbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant (Address) Harry Smith 509 Leadenhall St

Filed MAR 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 12th, 1923, to Feb. 27th, 1923, that I last saw h[illegible] alive on Feb 27th, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? No Date of c

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Carroll, M. D.

3/1, 1923 (Address) 1400 Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	March 3, 23
20 UNDERTAKER	ADDRESS 1[illegible] W Hoff St
Jno. H. Toadvine	

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73211

CERTIFICATE OF DEATH.

29 D73211

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 Vine ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Reid

(a) RESIDENCE. No. 835 Vine ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Abraham Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ellen Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Ruth Drummond

(Address) 535 Vine St

MAR 2 -1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1923, to Feb 27, 1923

that I last saw her alive on Feb 27, 1923

and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis + nephritis

Indefinite (duration) yrs. 8 (?) mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John C. Hobbs, M. D.

, 19 (Address) 753 E. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	3-2 1923
20 UNDERTAKER	ADDRESS 142 Uhler St
Jno. H. Toadvine	

D73212

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

1923 D73212

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1819 Linden ave ST. 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Yetta Lasky

(Residence in Baltimore: No. 1819 Linden ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	White	M

6-DATE OF BIRTH, About ....., 1897
(Month) (Day) (Year)

7-AGE, 26 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto city Md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Fanny L. Sachs

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto ✓

15-

Filed APR 2-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2-28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

gun shot wounds
Cerebral Hemorrhage Homicide
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
Coroner
March 1, 1923 (Address) [redacted] 780 Edmondson ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Lebanon Cemetery Rus	3-2-, 1923
20-UNDERTAKER	ADDRESS
Fast Levis	1439 E. Balto

D73213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 506 W. Fayette St.; WARD) 9

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank G. Weller

(Residence in Baltimore: No. 2074 Aiken St.; 55 yrs., 4 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Oct. 12th, 1867 (Month) (Day) (Year)

7-AGE, 55 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sugar Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Weller

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Adaline Cloudy

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. E. Weller

(Address) 2074 Aiken St.

15- ROBERT R. KRAUTER,

Filed MAR 2 - 1923 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 28th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy Fall

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) mos. ds.

(Signed) C. E. Wades M. D.

(Coroner.)

Mar 2 1923 (Address) 1437a Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, London Park

DATE OF BURIAL, March 3rd, 1923

20-UNDERTAKER, Mr. & Mrs. John W. Teufel & Son

ADDRESS 801 W. Fayette St

Spec.—1-10-23—M&T—1500 Blks.

D73214 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 101-001 D73214

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Rosekemp Ave ST., 27 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Stassfoth

(a) RESIDENCE NO. 22 Rosekemp Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced (or) WIFE of Chas. A. Stassfoth

6 DATE OF BIRTH (month, day, and year) Sept 28th 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
80.	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Earle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Earle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Elizabeth W. Mosher
(Address) 22 Rosekemp Ave

Filed MAR 2 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25. 1923, to Mar 1. 1923.
that I last saw her alive on Mar 1, 1923
and that death occurred, on the date stated above, at 4. 1. m.
The CAUSE OF DEATH* was as follows:
(Bilateral) Lobar Pneumonia

(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Arteriosclerosis & Mitral Regurgitation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas Simms, M. D.
3/1, 1923 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 3. 1923
20 UNDERTAKER	ADDRESS
Wm. H. Smith Funeral Home.	801 W. Fayette

D73215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73215

CERTIFICATE OF DEATH.

100-001

5

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 621 N. Eden St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Summers

(Residence in Baltimore: No. 621 N.Eden St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	Colored	Single

6-DATE OF BIRTH.

may (Month) (Day) 1922 (Year)

7-AGE. yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John Summers

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Mildred Pierce

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Milderd P.Summers

(Address) 621 N.Eden

MAR 2 - 1923 192 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 1/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J S H Oden M. D.
(Coroner.)

2/2/23 192 (Address) 508 E.North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel	March 2, 1923
20-UNDERTAKER. John W Henderson	ADDRESS 1502 E Monument

Spec.—3-10-21—M&T—1500 Bks.

D73216 HEALTH DEPARTMENT—CITY OF BALTIMORE D73216

CERTIFICATE OF DEATH. 202

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Howard

(a) RESIDENCE No. Bay View Asylum. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER ? Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? Unknown (State or country)

Informant Municipal Hospital Records.

(Address)

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1923

March 19, 1920

I HEREBY CERTIFY, That I attended deceased from [redacted], to February 27, 1923, that I last saw him alive on February 27, 1923, and that death occurred, on the date stated above, at 6:56 P.M.

The CAUSE OF DEATH* was as follows:

Foreign body in Pharynx

(Duration) yrs. mos. 4 Hrs. da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 4 Hrs. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Clyde McNeil, M. D.

2-28 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	March 14 1923
20 UNDERTAKER	ADDRESS
Milton Davis	365 N Eden St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73217

CERTIFICATE OF DEATH.

D73217

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 Church st Curtis Bay; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Howard Davis

(Residence in Baltimore: No. 211 Church st. Curtis Bay; 3 yrs. 3 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov. (Month) 25 (Day), 1919 (Year)

7-AGE.	If LESS than 1 day, ...hrs. or.....min.?
3 yrs. 3 mos. 3 ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Blackman Davis

11-BIRTHPLACE OF FATHER (State or Country), Philadelphia, Pa.

12-MAIDEN NAME OF MOTHER Eliza Butler Julian

13-BIRTHPLACE OF MOTHER (State or Country), Greene, N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Blackman Davis

(Address) 211 Church St. Curtis Bay

MAR 2 - 1923 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 27 1923, to Feb 28 1923, that I saw him alive on Feb 28 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho Lobular

(Duration)..... yrs..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Charles Lewis Jarlin M. D.

Feb 28 1923 (Address) 1017 St. Paul St. Baltimore Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery	Mar 2., 1923.
20-UNDERTAKER	**ADDRESS**
John F. Denny	715 Light St

Spec.—1-1921—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73218

CERTIFICATE OF DEATH.

129 D73218

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pennington Ave Ext ST., County Roy 25 WARD)

2-FULL NAME Charles A Chase

(a) RESIDENCE NO. Pennington Ave Ext ST., 25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M Chase

6 DATE OF BIRTH (month, day, and year) June 11 1863

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

10 NAME OF FATHER John A Chase

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha A Parke

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

Informant Mrs Emma M Chase

(Address) Pennington Ext.

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1 - , 1922, to March 1 , 1923, that I last saw him alive on Feb. 27 , 1923, and that death occurred, on the date stated above, at 1, a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of –

Was there an autopsy? No

What test confirmed diagnosis? Exam. Urine

(Signed) William H Jack M. D.

Mar 1, 1923 (Address) 816 Pennington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hurley M P Church Cemetery " " Co	Mar 4 1923
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

Spec.—6-2-19—H. P. Co.—1000 Bks.

D73219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73219

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2433 Maryland Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Aaron

(a) RESIDENCE. NO. 2433 Maryland Av ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Alice M Aaron

6 DATE OF BIRTH (month, day, and year) Mar 15 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cam Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Specialties 086

(c) Name of employer Proprietor

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md

10 NAME OF FATHER Marcellus Aaron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md

12 MAIDEN NAME OF MOTHER Emily Tall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Alice M Aaron (Wife)
(Address) 2433 Maryland Ave

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1923

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..., M. D.

..., 19... (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 3 1923
20 UNDERTAKER	**ADDRESS**
John F Denny	715 Light St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73220

CERTIFICATE OF DEATH.

90 D73220

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 W. Patterson Pk Ave ST., 8 WARD)

2-FULL NAME Eugene S. Tucker

(a) RESIDENCE No. 1113 W. Patterson Pk Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Tucker

6 DATE OF BIRTH (month, day, and year) Oct 11, 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Penna 073

(c) Name of employer Railroad

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Lamb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Minnie Tucker

(Address) 1113 W Patterson Pk Ave

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27th 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922 to Feb 27, 1923.

that I last saw him alive on Feb 26, 1923

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) 5 yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Infirmary

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tendency

(Signed) Fred Runyon M. D.

2-28-23, 19 (Address) 1001 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Mar 2 19 23

20 UNDERTAKER Philip Herwig ADDRESS 20 E Orleans St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73221

CERTIFICATE OF DEATH.

100-001 ✓ D73221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 Orleans ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Horn

(a) RESIDENCE No. 2414 Orleans ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Adam Horn

6 DATE OF BIRTH (month, day, and year) Nov 21st 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Distler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Anna Pierce

(Address) 2414 Orleans St.

Filed MAR 2 - 1923 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Mar 1, 1923, that I last saw her alive on Feb 28, 1923, and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma - Chronic Bronchitis. Senile debility

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchitis Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adm B Lemmon, M. D.

3/2, 1923 (Address) 7158 Pattison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cem.	Mar. 4 1923
20 UNDERTAKER	ADDRESS
Philip Herring	Orleans St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73222

CERTIFICATE OF DEATH.

90 D73222

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2432 Greenmount Ave ST., 17 WARD)

2-FULL NAME Mary Goldfield

(a) RESIDENCE No. 2432 Greenmount Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Goldfield

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Max Mostovitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Gitel Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Jack Lewis
(Address) 1439 E Baltimore St

Filed MAR 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28th, 1922, to March 1, 1923, that I last saw her alive on March 1, 1923, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (mitral stenosis) Chronic Myocarditis -

(duration) 2 yrs. mos da.

CONTRIBUTORY (Secondary) Cerebral Embolism & right brachial artery embolism (duration) — yrs. — mos. 1 da.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? all signs & symptoms

(Signed) M D Lewis, M. D.

3/2, 1923 (Address) 726 Walbert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Man — DATE OF BURIAL 3/2 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73223

CERTIFICATE OF DEATH.

100-01 D73223

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2836 Elmora ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Krajna

(a) RESIDENCE NO. 2836 Elmora ST. 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5- 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~11~~	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

10 NAME OF FATHER Stephen Krajna

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Wochnyk

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

Informant Stephen Krajna
(Address) 2836 Elmora St

Filed MAR 2 1923 ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to Feb 27, 1923, that I last saw h.e alive on Feb 27, 1923, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Roan M. D.

(Address) Feb 28 1923 801 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Mar 1 1923
20 UNDERTAKER	ADDRESS
Stephen J Pawlikowski	1000 Hanover av

Spec.—1-10-21—M&T—1500 Bks.

D73224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73224

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 N. Belnord Ave 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Lynch

(a) RESIDENCE No. 231 N. Belnord ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced, HUSBAND of (or) WIFE of Ella Lynch

6 DATE OF BIRTH (month, day, and year) Dec 2 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Officer

(b) General nature of Industry, business, or establishment in which employed (or employer) Standard Oil Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER John Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Ella Lynch

(Address) 231 N. Belnord Ave

Filed 2-1923, 19 Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 28, 1923,

that I last saw him alive on July 27, 1923,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles O'Donovan, M. D.

(Address) 5 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	3/3/1923

20 UNDERTAKER J A Moran

ADDRESS 3000 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73225 ✓ D73225

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 527 Robert St. (ST.) 14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Beale

(a) RESIDENCE. NO. 527 Robert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mamie Beale

6 DATE OF BIRTH (month, day, and year) May 21 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer John Trew

BIRTHPLACE (city or town)
(State or country) Essex Co Va.

10 NAME OF FATHER Horace Beale

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mildred Newton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

Informant Mamie Beale
(Address) 527 Robert St

Filed Feb 2 — 1923 19

ROBERT N. KRAUTER
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Feb 26, 1923, that I last saw him alive on Feb 26, 1923, and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) 2 yrs. 1/2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

Mar 1, 1923 (Address) 1413 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3/2 1923
20 UNDERTAKER	ADDRESS 578
Samuel Townsend	W Biddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73226

CERTIFICATE OF DEATH.

57

D73226

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 George ST. 17 WARD)

2-FULL NAME Annie E. Johnson

(a) RESIDENCE. No. 709 George ST., WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Liddleton Johnson

6 DATE OF BIRTH (month, day, and year): Dec 7 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carrollton Md

10 NAME OF FATHER: Isaac Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lucinda Chandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Annie E. Hammond

(Address)

Filed [illegible] 19[illegible]

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7 19 23

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 19 22 to Feb 7 19 23

that I last saw h[illegible] alive on Feb 7 19 23

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 (Address) 1413 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2/9 19 23
20 UNDERTAKER	ADDRESS
Sam'l T Kemp	578 W Fayette

Spec. 6-9-19 H. P. Co. 1000 Bks.

Raspburg ✓

D73227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73227

CERTIFICATE OF DEATH.

100-601

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 64 (Baltimore Co.) (St.) 26 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond E. Polley

(a) RESIDENCE. No. 64 Balto Co Raspeburg, St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Thomas E Polley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Eugenia Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Thomas E Polley
(Address) 64 Baltimore Co.

MAR 2 - 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28. 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 15th, 1923, to Feb 28, 1923, that I last saw h[illegible] alive on Feb 27, 1923, and that death occurred, on the date stated above, at 6 A. m. The CAUSE OF DEATH* was as follows:

B. Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Marasmus.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav A. Graf, M. D.

3/1, 1923 (Address) Overlea.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	3/2 1923
20 UNDERTAKER	ADDRESS
Martin Funeral Home	837 W North

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73228 — CERTIFICATE OF DEATH. — 113 — D73228

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 905 N. Bontoga St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Smallwood

(a) RESIDENCE. NO. 905 N. Bontoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto city

10 NAME OF FATHER Geo Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Annie Jones
(Address) 905 N Bontoga St

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from Feby 28, 1923, to March 1st, 1923
that I last saw h[illegible] alive on Feby 28th, 1923,
and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:

Indigestion - Convulsions

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Capt. J. Mooney, M. D.
(Address) 560 N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 2 1923

20 UNDERTAKER R. E. Gross ADDRESS 1405 Madison

Spec.—1-10-21—M&T—1500 Bks.

Rosa Jackson

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D73229

46 D73229

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 St James ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Jackson

(a) RESIDENCE NO. 120 St James ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Simms

6 DATE OF BIRTH (month, day, and year): 6/12/1880

7 AGE: Years: +2 Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

Informant: Wm Simms

(Address) 120 St James St

MAR 2 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 12 1923 to Feb 28 1923 that I last saw her alive on Feb 28 1923, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis from Carcinoma of Uterus

(duration) ? yrs. ? mos. 15 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus (duration) 1 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geo L Wall, M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: 3/2 1923

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Blks.

D73230

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D73230

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 Edmondson Ave. WARD 17)

2-FULL NAME Margaret A. Dempsey

(a) RESIDENCE No. (816 Edmondson Ave.) ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ (or) WIFE of Michael J. Dempsey

6 DATE OF BIRTH (month, day, and year) Feb 4 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) County Kerry Ireland
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Fahey

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

Informant John E. Dempsey
(Address) 2016 Pennsylvania Ave

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1923, to Feb 28, 1923, that I last saw h[illegible] alive on Feb 28, 1923, and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (secondary) Chronic Valvular Heart Disease (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Paul Brown M.D.

2/28, 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 3-3-1923

20 UNDERTAKER H. C. Brauning & Son — ADDRESS 51 N Schroeder St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73231

CERTIFICATE OF DEATH.

101-001 D73231

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 East Chase Street St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Joseph Peat.

(a) Residence No. 711 East Chase Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 18, 1922

7-AGE.	If LESS than 1 day,
...yrs. 6 ...mos. 10 ...ds.	...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto.
(State or Country), Md.

10-NAME OF FATHER, William A. Peat

11-BIRTHPLACE OF FATHER (city or town)..... Balto.
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret O'Conor

13-BIRTHPLACE OF MOTHER (city or town)..... Balto.
(State or Country), Md.

(Informant) Wm. A. Peat

(Address) 711 E. Chase St.

MAR 2 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1923 to Feb. 27, 1923 that I last saw h. im alive on Feb. " 1923, and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ...yrs. ...mos. 9 ...ds.

CONTRIBUTORY (Secondary) Convulsion

(Duration) ...yrs. ...mos. 3 ...ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?... No. Date of "

Was there an autopsy?.....

What test confirmed diagnosis?... Clinical

(Signed) Edw. J. Coolahan, M. D.

2/28, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
New Cathedral	Mar. 2, 23.
20-UNDERTAKER.	ADDRESS
H. C. Wiedefeld	914 Greenmount Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73232

CERTIFICATE OF DEATH. 11-001

D73232

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1370 Whatcoat ST., 15 WARD)

2-FULL NAME Mary Elizabeth Savage

(a) RESIDENCE No. 1370 Whatcoat ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year) Feb 20/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Edward Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Tula Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Tula Savage
(Address) 1370 Whatcoat St

MAR 2 - 1923

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to Feb 28, 1923, that I last saw h[illegible] alive on Feb 27, 1923, and that death occurred, on the date stated above, at 10.20 A m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(durstion) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. Williams Frey, M. D.

3/1, 1923 (Address) 731 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn.	3/2 1923

20 UNDERTAKER James R. Lewis ADDRESS 303 E Lanvale

Spec. 1-10-21—M&T—1500 Blks.

D73233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D73233

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 876 W. Fayette ST. 18 WARD)

2-FULL NAME William Stepp

(a) RESIDENCE No. 876 W. Fayette ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Stepp

6 DATE OF BIRTH (month, day, and year) Jan 17, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	43	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Tube. Co.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

16 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

Informant Clara Stepp
(Address) 876 W. Fayette st.

Filed MAR 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 30, 1923, to March 1, 1923, that I last saw him alive on March 1, 1923, and that death occurred, on the date stated above, at 2.05 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Thos Conlon, M. D.

3/2, 1923 (Address) 888 N. Luzerne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nuture of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Mar 3 1923
20 UNDERTAKER	ADDRESS
Mrs. Mrs. J. W. Gempfel & Son	801 N. Fayette

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE 3/ D73234

D73234

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cherry Ave, near Rose Ave ST., Overlea WARD)

2-FULL NAME George Muller

(a) RESIDENCE NO. Cherry Ave. near Rose ave. Overlea ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 10th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Farm 040

(c) Name of employer Overlea Realty Co.

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Joseph Coster

(Address) Overlea Md

MAR 2 - 1923 ROBERT R. KRAUTER, Register

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 1, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1923, to Mch. 1, 1923,

that I last saw him alive on Feb. 28, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Williamson, M. D.

3/3/1923 (Address) Cockeysville, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 3, 1923
20 UNDERTAKER	ADDRESS
Keith Lescalm & Sons	Fullerton

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73235

D73235

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Wilcox ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora A. Kraft.

(a) RESIDENCE NO. 1100 Wilcox ST., 10 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married ~~widowed~~ or divorced (or) WIFE of George Kraft.

6 DATE OF BIRTH (month, day, and year) June 2nd 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER John Schwerdt.

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Wagner

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant (Address) Mr. George Kraft. 1100 Wilcox st

Filed 1923 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1922, to Feb 28th, 1923, that I last saw her alive on Feb 28th, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. ? mos ds.

CONTRIBUTORY (Secondary) Mutual Life Insurance Co. of New York

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physician + Laboratory

(Signed) L. McCarter, M. D.

1923 (Address) 1114 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 3, '23
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1801 E. Eager st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73236

CERTIFICATE OF DEATH.

3 D73236

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3150 Leeds Ave ST., 20 WARD)

2-FULL NAME Louis Lunard Waldhauser

(a) RESIDENCE NO. 3150 Leeds ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 27. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Sebastian Waldhauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Zang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

Informant Emma Waldhauser.
(Address) 3150 Leeds St.

1923 Robert P. Harrison, ... 19 .....
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28- 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Feb 28, 1923, that I last saw h alive on Feb 28, 1923 and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Clifford Dunn, M. D.

, 19 (Address) 1509 Woodbourne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 3, 1923
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk. Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73237

CERTIFICATE OF DEATH.

90 D73237

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Mitchell

(a) RESIDENCE NO. 2316 E. Oliver St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	--	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country) Vermont

10 NAME OF FATHER Arthur Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan

12 MAIDEN NAME OF MOTHER Catherine Higginson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

Informant (Address) Municipal Hospital Records.

Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1923

17

I HEREBY CERTIFY, That I attended deceased from February 10 1923. to February 26 1923.

that I last saw him alive on February 26, 1923,

and that death occurred, on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) 10 yrs. mos. da.

CONTRIBUTORY (Secondary) Arterial embolism

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Reed, M. D.

19 (Address) Municipal Hospital. 2-27-23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Registered MAR 2 1923

Spec.—1-10 21—M&T—1500 Blks.

D73238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73238

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Ostrich

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 21

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louiseville, Kentucky

10 NAME OF FATHER J.C. Ostrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Fryer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant (Address) Municipal Hospital Records.

Robert P. Harrison, M.D. Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1923

17

I HEREBY CERTIFY, That I attended deceased from February 23, 1923, to February 26, 1923, that I last saw him alive on February 26, 1923, and that death occurred, on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde M. Reed M. D.

2-27 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER Commissioner Health. Per. Wm. E. WOODALL	ADDRESS 2 1923

D73239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73239

CERTIFICATE OF DEATH.

31

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 Nursery alley St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Pleasant E. Davis

(Residence in Baltimore: No. 1012 Nursery alley St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: C

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH,

.....(Month) .....(Day) .....(Year)

7-AGE: 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd J.

9-BIRTHPLACE, (State or Country): Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Robert P. Harrison,

1923 ..... 192 ..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Chronic I. C. —

Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Clinton Blake M. D.

Mar 1923 (Coroner.)

192.. (Address) 43 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL DATE OF BURIAL, MAR 2 1923

20-UNDERTAKER, ... ADDRESS .....

Commissioner Health.

For Wm. T. Howard

0165 THE MORAU

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73240 ✓ 99-007 D73240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Schaffer ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L Ernsberger

(a) RESIDENCE NO. 14 Schaffer ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Blanche L. Ernsberger

6 DATE OF BIRTH (month, day, and year) Nov 30th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

10 NAME OF FATHER Jacob Ernsberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Sallie A Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

Informant Blanche L. Ernsberger

(Address) 14 Schaffer ave

1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to March 1, 1923

that I last saw him alive on March 1, 1923

and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis -

Senile decay of Heart.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) W J Gehrig, M. D.

(Address) 6 7 7 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	March 3rd 1923
20 UNDERTAKER	ADDRESS
George S Schilling & Sons	[illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73241

CERTIFICATE OF DEATH.

57 D73241

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 Mosher ST. 14 WARD)

2-FULL NAME Philip Snyder

(a) RESIDENCE NO. 143 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of ~~(or WIFE of)~~ Cornelia Snyder

6 DATE OF BIRTH (month, day, and year) June 22nd 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk 09

(b) General nature of industry, business, or establishment in which employed (or employer) American Tobacco Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs Cornelia Snyder

(Address) 143 Mosher St

1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1917, to March, 1923, that I last saw ~~him~~ alive on Feb 28, 1923, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John P. Fields, M. D.

3/1, 1923 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Spring Cemetery Harford Co Md	Mar 8th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1121 E Monument St

Burial Permit Clerk.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73242 41 D73242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2513 Francis St. 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos E. Lassiter

(Residence in Baltimore: No. 2513 Francis St.; 5 yrs., 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 21, 1922
(Month) (Day) (Year)

7-AGE, 5 yrs. 5 mos. 10 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

10-NAME OF FATHER, Geo. W. Lassiter Sr.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Sarah E. Slifer

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co. Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Lassiter Sr.

(Address) 2513 Francis St.

Robert P. Harrison,
1923 ....., 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1923, to Mar 2 1923, that I saw him alive on Mar 2 1923, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

General Septic Infection (Focal)

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Chronic Malnutrition

(Duration) ....yrs. 4 mos....ds.

(Signed) Thos Lloyd M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn | DATE OF BURIAL, Mar 3, 1923

20-UNDERTAKER Wm H. Sills | ADDRESS 2198 Edmondson Av

Spec.—1-10-21—M&T—1500 Blks.

D73243

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D73243

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 Windsor Avenue ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Harry Macatee

(a) RESIDENCE NO. 3012 Windsor Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hopper, McGaw & Co.

BIRTHPLACE (city or town) Harford Co.
(State or country) Maryland

10 NAME OF FATHER Henry Macatee

11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Margaret Ramsay

13 BIRTHPLACE OF MOTHER (city or town) Near Constitution
(State or country) Pennsylvania

Informant (Address) Joseph E. Watkins Jr 2304 N. Calvert Street

23 Jul 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1923

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1923 to Mar 1, 1923, that I last saw h[illegible] alive on Mar 1, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Left side)
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Claude, M. D.

19 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery Harford Co., Md.

DATE OF BURIAL 3/3 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

D73244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. University Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C Wells

(Residence in Baltimore: No. Patapsco md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Dont Know (Month) (Day) 1 (Year)

7-AGE: 9 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Patapsco Md

10-NAME OF FATHER: Floyd Wells

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country): Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J F Reese

(Address) Freshmeadow Md

Robert P. Harrison, Registrar.

1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ Inquest thereon and from the evidence obtained by said ~~Inquest, autopsy or~~ Inquest find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by automobile a few hrs

(Duration) yrs. mos. ds.

(Signed) H H Jarrell M. D.
(Coroner.)

3 2 1923 (Address) 117 N Saratoga

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Westminster Md — DATE OF BURIAL: March 1923

20-UNDERTAKER: W M Routzon — ADDRESS: 2238 Madison

D73245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73245

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH. Registered No. C.....

City of BALTIMORE: (No. Pronounced dead at St. Joseph Hosp. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Beloate

(Residence in Baltimore: No. 817 Whatcoat St.; yrs. 17 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the Word.)
female	colored	Married

6-DATE OF BIRTH. Jan 23/1883 (Month) (Day) (Year)

7-AGE. 40 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Washington D.C.

10-NAME OF FATHER. John Terrel

11-BIRTHPLACE OF FATHER. (State or Country). Wash.D.C.

12-MAIDEN NAME OF MOTHER. Annie Parker

13-BIRTHPLACE OF MOTHER. (State or Country). Culpepper, Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Cassell

(Address) 926 N STricker

1923 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 28/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Paitsell M. D. (Coroner.)

3/2/23 (Address) 500 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Int. Pulaski Cem.	3 1923
20-UNDERTAKER.	ADDRESS
Jos. R. Skinner	1625 E. Fred. St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73246

CERTIFICATE OF DEATH.

118-002 D73246

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 18 WARD)

2-FULL NAME Miss Irene Mullen

(a) RESIDENCE NO. 1212 W. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26/904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	18	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Cigar factory employe

(c) Name of employer

BIRTHPLACE (city or town) Balto (State or country) Maryland.

10 NAME OF FATHER John Mullen

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Karoulaki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mary Mullen

(Address) 2235 Decker st

1923 Robert F. Harrison, . 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1923, to Feb. 28, 1923, that I last saw her alive on February 28, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction with General peritonitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 26, 23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Fulton, M. D.

. 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Ft. Stanislaus — DATE OF BURIAL Mar 3 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73247 D73247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Garrison Lane ST.; 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Grace Volkmann

(a) RESIDENCE. No. 118 Garrison Lane ST.; 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? —yrs. —mos. —ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Volkmann

6 DATE OF BIRTH (month, day, and year) Nov 24-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER John A Walper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Bertie Lange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

Informant (Address) Chas Volkmann 118 Garrison Lane

Filed 1923

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17

I HEREBY CERTIFY, That I attended deceased from August 4, 1922, to March 1, 1923.

that I last saw h-er alive on March 1, 1923

and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H A Brueckner M. D.

, 19 (Address) 1328 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Mar 4 1923
20 UNDERTAKER	ADDRESS
H. B. Hepburn	2236 Fleet Ave

D73248

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001

D73248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 717 E. Preston St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar L. Ritchie

(Residence in Baltimore: No. 717 E. Preston St.; yrs. 21 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	single

6-DATE OF BIRTH. APRIL KK--- (Month) (Day) 1892 (Year)

7-AGE. 30 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Washington Co. Va.

10-NAME OF FATHER. J.W.Ritchie

11-BIRTHPLACE OF FATHER, (State or Country). VA.

12-MAIDEN NAME OF MOTHER. Laura Berry

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D.G.Ritchie

(Address) Meadow View Va.

923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 28/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Asphixiation- Accidental

Defective appliance. Gas hose and burner

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J S B Davis M. D. (Coroner)

3/2/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Meadow View Va. DATE OF BURIAL. 3/7 1923

20-UNDERTAKER. D. Harrison & Bro ADDRESS 1127 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Dingledein)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73249 129 D73249

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hommond Hospital

CITY OF BALTIMORE: (NO. 2724 N Chas ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Dingledein

(a) RESIDENCE. NO. 1020 S. Kenwood av ST. City WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 4 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Dingledein

6 DATE OF BIRTH (month, day, and year) Mar 9 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	63	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mr. Chas Bohn (Address) 2205 E Pratt St

Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1922 to Mar 1 1923

that I last saw him alive on Mar 1 1923.

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Influenza Neglected Uremia

(duration) 5 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine Test

(Signed) George I Louik M. D.

, 19 (Address) 912 N Madison st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Mar 4 1923

20 UNDERTAKER Peter Nicolaus ADDRESS 3060 Eastern Av

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73250

CERTIFICATE OF DEATH.

100-001

D73250

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 652 Redwood ST., 4 WARD)

2-FULL NAME Alex. Trubka

(a) RESIDENCE NO. 652 Redwood ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Sometimes mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 11. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Saml - Trubka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mantusky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) Saml Trubka 652 Redwood St

Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1923, to March 1, 1923

that I last saw him alive on March 1, 1923

and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia 5

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Hillinger M. D.

2/2. 1923 (Address) 687 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery	March 3 1923
20 UNDERTAKER	ADDRESS
Leo Leimbach & Son	647 W Pratt St

Spec.—1-10-21—M&T—1509 Bks.

Silsbury Cedar Croft

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73251

CERTIFICATE OF DEATH.

11-002 D73251

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 500 Franklin Street 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bren Edwards

(a) RESIDENCE NO. 500 Franklin Street WARD 9.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 16 '22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Francis Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Blanche Bren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Francis Edwards

(Address) 500 Franklin Street

Filed ....., 19 .....

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby. 22, 1923, to Mar. 1, 1923, that I last saw him alive on Mar. 1st, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis

Bacillus of Eyler

infection

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of Mar 1/23

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Wm J. Gillbour, M. D.

, 19 (Address) 1415 Cedarcroft Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 2 1923
20 UNDERTAKER	ADDRESS
H. McCurk	532 E. Fayette St.

(Maxiel G. Comfort)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73252

CERTIFICATE OF DEATH.

1888-90 D73252

(PLACE OF DEATH

CITY OF BALTIMORE (No. 4744 Park Heights Ave. ST. 57 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Maxiel G. Comfort

(Residence in Baltimore: No. 4744 Park Heights Ave. 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. Male

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6 DATE OF BIRTH Oct. 29, 1852 (Month) (Day) (Year)

7 AGE, 70 yrs. 4 mos. 0 ds. If LESS than 1 day, ...hrs. or ...min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Printer (b) General nature of industry, business, or establishment in which employed (or employer) 063

9 BIRTHPLACE, (State or Country) Pa.

PARENTS.

10 NAME OF FATHER Peter Comfort

11 BIRTHPLACE OF FATHER (State or Country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Middley

13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louisa M. Comfort

(Address) 4744 Park Heights Ave

15 Robert P. Harrison,

Filed ..... 191.....

23 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH March 28, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest aforesaid find that said deceased came to h... death (autopsy or inquiry.) on the day stated above.

18 CAUSE OF DEATH* was as follows: Bronchopneumonia Secondary Empyema Thoracis Right Pleural Accidental Shock (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ... (Duration) ...yrs. ...mos. ...ds.

(Signed) John J. Morrissey M. D. (Coroner)

Mar. 2, 1923 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL Gettysburg Pa. DATE OF BURIAL March 31, 1923

20 UNDERTAKER Milton H. Eares ADDRESS 424 N. Broadway

D73253

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D73253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 734 So. Bond ST.: 3 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Jesionowski

(Residence in Baltimore: No. 734 So. Bond) (St.: 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Apr 2nd (Month) (Day), 1865 (Year)

7-AGE, 57 yrs. 11 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Peter Jesionowska

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mary Wrubel

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Jesionowska

(Address) 734 So. Bond St

15- Mar 1923 Robert P. Harrison, 191..... Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch 2nd (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Thos B. Harris M. D.
(Coroner)

Mch 2nd, 1923 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Stanislaus	March 3, 1923
20-UNDERTAKER	**ADDRESS**
John H Weber	1803 Bank St

Spec. 1-1021 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73254

CERTIFICATE OF DEATH.

129 D73254

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bartos

(a) RESIDENCE No. 730 S. Bethel St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant Municipal Hospital Records.

(Address)

Filed Robert P. Harrison, Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17

I HEREBY CERTIFY, That I attended deceased from February 28, 1923, to March 1, 1923.

that I last saw him alive on March 1, 1923,

and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde M. Neel M. D.

3-2-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 5 1923
20 UNDERTAKER	ADDRESS
John Weber	803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73255

CERTIFICATE OF DEATH.

D73255

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1216 E. North Ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Bernstein

(a) RESIDENCE. NO. 1216 E. North Ave ST., WARD. Life 9th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): X

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21-1922

7 AGE: Years X; Months 8; Days 9; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Paul Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elenz Dudley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Paul Bernstein

(Address) 1216 E North Ave

Robert P. Harrison, Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1923 to March 2 1923

that I last saw him alive on March 2 1923

and that death occurred, on the date stated above, at 11.00 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) X yrs. X mos. 6 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) X yrs. X mos. 21 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? none Date of .....

Was there an autopsy? none

What test confirmed diagnosis? none

(Signed) O H Decker M. D.

3/2 1923 (Address) 928 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Rd.	Mar 8nd 1923
20 UNDERTAKER	ADDRESS
Leo G. Cook	North Harford

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73256

D73256

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3121 Fait Ave St. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Sebour

(a) RESIDENCE NO. 3121 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Sebour

6 DATE OF BIRTH (month, day, and year) Sept - 1845(?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
77	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alsace - Lorraine
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

Informant Mrs Margaret Sebour

(Address) 3121 Fait Ave

Robert F. Harrison,

Filed , 19 Registrar

923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 22 , 19 23 to Feb 27 , 19 23 ,

that I last saw h m alive on Feb 27 , 19 ,

and that death occurred, on the date stated above, at 2 10 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. L Burke, M. D.

2/28, 1923 (Address) 3042 Hudson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Mch 3 1923
20 UNDERTAKER	ADDRESS
H. Allen Faller	2902 Fairmount Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73257 — 1929 — D73257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 Gilmore ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Gumby

(a) RESIDENCE. No. 1230 Gilmore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Clara Gumby

6 DATE OF BIRTH (month, day and year) ~ 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	~	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster shucker

(b) General nature of industry, business, or establishment in which employed (or employer) ~ 9

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset County Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Maryland

Informant (Address) Mrs Clara Gumby 1230 Gilmore St

Filed 923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~Feb~~ Mar 1. 1923

17 I HEREBY CERTIFY, That I attended deceased from October 20, 1923, to ~~Feb~~ Mar 1, 1923 that I last saw h~~im~~ alive on March 1, 1923 and that death occurred, on the date stated above, at 12:15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) chronic valvular disease of heart (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of ~

Was there an autopsy? ~

What test confirmed diagnosis? physical signs & symptoms

(Signed) John E. D. Lamper, M. D.

19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Mch 4 1923
20 UNDERTAKER	**ADDRESS**
S. C. Brown & Son	108 W. Monty

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73258

D73258

CERTIFICATE OF DEATH.

101-601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 846 S Sharp ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Tripple

(a) RESIDENCE. NO. 846 S. Sharp ST. 22 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 20 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Benj. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Louise Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Sam. Tripple
(Address) 846 S Sharp St.

Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/28/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/15/23, 19 , to 2/28/23, 19 ,
that I last saw her alive on 2/27/23, 19 ,
and that death occurred, on the date stated above, at 7.40 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza and Bronchitis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Jurgonley, M. D.

2/28/23, 19 Address 908 S Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mch 3 1923
20 UNDERTAKER	ADDRESS 142
Jno N. Toadvine	Ustick St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73259

CERTIFICATE OF DEATH.

11-00 D73259

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 Dolphin St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J Young

(Residence in Baltimore: No. 618 Dolphin St.; 69 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1859 (Year)

7-AGE. 69 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country). Maryland

10-NAME OF FATHER. Cyrus Carpenter

11-BIRTHPLACE OF FATHER (State or Country). md

12-MAIDEN NAME OF MOTHER. Elizabeth Sowell

13-BIRTHPLACE OF MOTHER (State or Country). md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred Young

(Address) 618 N Dolphin St

Robert P. Harrison, ... 191... Registrar.

923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 22 1923, to Feb 28 1923, that I saw her alive on Feb 27 1923, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ... yrs. ... mos. 35 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. ... mos. ... ds.

(Signed) H. S. McCarty M. D.

3/2, 1923 (Address) 2045 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn

DATE OF BURIAL. March 3, 1923

20-UNDERTAKER Jno. W. Toadvine

ADDRESS 172 W Hill St.

Spec.—1-10-21—M&T—1500 Bks.

D73260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73260

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Caroline ST., 1 10 WARD)

2-FULL NAME Anna H. Finke

(a) RESIDENCE NO. 1023 N. Caroline ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of the late Frank A. Finke

6 DATE OF BIRTH (month, day, and year) Aug. 30 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	6	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (city or town) Balto Md.
(State or country)

10 NAME OF FATHER John Fraun Lolz

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna Rice

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Mrs. J. Harry Finke
(Address) 2776 Alameda Ave

1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to March 1, 1923, that I last saw deceased alive on March 1, 1923, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe, Acute Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular disease of Heart

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gehrig, M. D.

3/12, 1923 (Address) 6114 N. Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL March 15 1923

20 UNDERTAKER Henry Hardt & Son

ADDRESS 320 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73261

CERTIFICATE OF DEATH.

11-00 D73261

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2138 E Oliver ST., 8 WARD)

2-FULL NAME Regina J. Bailey

(a) RESIDENCE NO. 2138 E Oliver ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 7 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Schl. school

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) Balto. Md
(State or country)

10 NAME OF FATHER William T. Bailey

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country)

12 MAIDEN NAME OF MOTHER Julia May Barrett

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

Informant Mr. Julio M. Barrett.
(Address) 2138 E. Oliver St.

Robert P. Harrison,
Registrar

373 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1 1923 to March 2 1923,

that I last saw her alive on ..... 19....,

and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Influenza 5 days.
acute attenuex Rheumatism 40 yrs
Broncho Pneumonia 7 days

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Mitral Regurgitation Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos Fa Stevens M. D.

3/3/1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	March 6 1923
20 UNDERTAKER	**ADDRESS**
Henry Hoed Law	1301 E Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73262

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1935 Herbert St. St. 13 Ward)

2-FULL NAME Baby Garrett

(a) RESIDENCE. No. 1935 Herbert St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 3-2-23

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

10 NAME OF FATHER John Garrett.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Alice Hepburn

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant John Garrett
(Address) 1935 Herbert St

Filed 1923, 19 Robert P. Harrison, Registrar

Burial Permit Cleric

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2-1923

17 I HEREBY CERTIFY, That I attended deceased from 3-2, 1923, to 3-2, 1923, that I last saw h[illegible] alive on 3-2, 1923 and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia from Pallidex.

Instrumental

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/3/23 (Address) 2757 Wyoming Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	3/3/23
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73263

CERTIFICATE OF DEATH.

38 D73263

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester Walton.

(a) RESIDENCE No. 1529 E. Pond St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) April 1 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 87

(c) Name of employer L. Hemiplegia

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Municipal Hospital Records.

(Address)

Filed March 2, 1923 Robert F. Harrison, Registrar

23 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1923, to March 2, 1923, that I last saw him alive on March 2, 1923, and that death occurred, on the date stated above, at 9:40 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 15-20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebro spinal Syphilis

(duration) 10? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

(Address) March 2, 1923 Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leader Park — DATE OF BURIAL March 5, 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E. Fort Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D73264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73264

CERTIFICATE OF DEATH.

93

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1931 Hurlst St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lenhoff.

(a) Residence No. 1931 Hurlst St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Lenhoff

6-DATE OF BIRTH (month, day and year) Jan. 1. 1850.

7-AGE, 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

10-NAME OF FATHER, John Lenhoff

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

(Informant) Lena Lenhoff

(Address) 1931 Hurlst St.

Robert P. Harrison,
Registrar.

23 192.....
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 2/23

17- I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923 to Mar 2, 1923 that I last saw him alive on Mar 2, 1923 and that death occurred, on the date stated above, 2.40 a.m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza Grippe

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

3/2, 1923 (Signed) E. W. Schneider, M. D.

(Address) 712 Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Trinity Cem't

DATE OF BURIAL, Mar 6, 1923

20-UNDERTAKER William Cook & Nathan

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D73265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73265

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2518 Wilkens Ave. ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Barrett

(a) RESIDENCE NO. 2518 Wilkens Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Barrett

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
81	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER John Byrnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Delaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs. Catherine E. Farley

(Address) 2518 Wilkens Ave.

Filed 3/3, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 2" 19 23

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to March 2, 1923.

that I last saw h[illegible] alive on March 1, 1923,

and that death occurred, on the date stated above, at 12.20P m.

The CAUSE OF DEATH* was as follows:

Apter Delegris Endocarditis

Chr Interstitial Nephritis

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C Nitsch, M. D.

3/2, 1923 (Address) 2151 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mch. 5 1923
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 W. Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73266

CERTIFICATE OF DEATH.

58-001 D73266

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2517 Francis St. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Joseph Hiltner

(a) RESIDENCE NO. 2517 Francis St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie L. Hiltner

6 DATE OF BIRTH (month, day, and year) Jan. 27th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman, American

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER John Hiltner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Yost

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Maggie L. Hiltner (Address) 2517 Francis St.

Filed Robert P. Harrison, Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 18th 1923, to Mch 2nd 1923, that I last saw him alive on Mch 1st 1923, and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. 3 mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no microscopic

What test confirmed diagnosis? Blood Examination

(Signed) Chas. H. Bubert, M. D.

3/2. 1923 (Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk. Cemetery	Mch. 5 1923
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 W. Balto St.

Spec.—1-10-21—M&T—1500 Rls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73267

CERTIFICATE OF DEATH.

23 D73267

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Friendsbury St. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles O. Jones

(a) RESIDENCE NO. 1724 Friendsbury ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 28" 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Oliver C. Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Braun

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

Informant Allen T. Harris
(Address) 1724 Friendsbury St.

Feb 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28" 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923, to Feb 28, 1923, that I last saw him alive on Feb 28, 1923, and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargytica

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

3/25/23 (Signed) E Heller Hemming, M. D.

(Address) Hollins & Payson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Mch. 3 1923
20 UNDERTAKER	ADDRESS
Jos. Cook	1003 W. Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78268

CERTIFICATE OF DEATH.

129 D73268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 79 Main St. Hillsdale St., Md. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Haney Sr.

(a) RESIDENCE NO. 79 Main St. Hillsdale St., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie May Haney

6 DATE OF BIRTH (month, day, and year) July 17th 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer Stationary

(b) General nature of industry, business, or establishment in which employed (or employer) (Steam)

(c) Name of employer

9 BIRTHPLACE (city or town) Highfield (State or country) N. J.

10 NAME OF FATHER William Haney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs. Wm. Haney

(Address) 79 Main St. Hillsdale, Md.

3/4 ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to Mch 1st, 1923, that I last saw him alive on Feb 28, 1923, and that death occurred, on the date stated above, at 11.04A. m.

The CAUSE OF DEATH* was as follows: Chronic Paranephritis Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chemical & Clinical

(Signed) A. C. Smith M. D.

3/1, 19 23 (Address) 4509 Liberty Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Mch. 5 1923
20 UNDERTAKER	ADDRESS
Jas B Cook	1003 W. Balto

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 D73269

D73269

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 S. Monroe St. ST., 19 WARD)

2-FULL NAME Dora Good

(a) RESIDENCE NO. 539 S. Monroe St. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Gutt

6 DATE OF BIRTH (month, day, and year) May 10" 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	88	9	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs. Elizabeth King
(Address) 539 S. Monroe St.

1923 Robert P. Harrison, 19 Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 2" 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to March 2, 1923, that I last saw h alive on March 2" 1923, and that death occurred, on the date stated above, at 10.30A. m.

The CAUSE OF DEATH* was as follows:

Senile Dreng-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edw. Jenkins, M. D.

3/2. 1923 (Address) 519 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk. Cemetery	Mch 5 1923
20 UNDERTAKER Jas B. Cook	ADDRESS 1003 W. Balto

D73270

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-D73270

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Oak Grove Farm ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie Poe

(Residence in Baltimore: No. Oak Grove Farm Deering near Bushes Lane St.; 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Feb 9 (Month), 1881 (Year)

7-AGE: 42 yrs. 1 mos. 19 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): M D

PARENTS

10-NAME OF FATHER: Thomas Poe

11-BIRTHPLACE OF FATHER (State or country): M D

12-MAIDEN NAME OF MOTHER: Mary Horton

13-BIRTHPLACE OF MOTHER (State or country): M D

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE

(Informant) H Parks

(Address) Oak Grove Farm

Robert P. Harrison

....., 191 REGISTRAR

23

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 2 (Month) / 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/27, 1923, to 2/28 1923, that I saw h[er] alive on 2/28 1923, and that death occurred, on the date stated above, at 6.00 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary (Branchial)

(Duration) yrs mos. 6 ds.

Contributory (SECONDARY)

(Duration) yrs mos. ds.

(Signed), Henry Cassell M. D.

.....191..... [Address] 3902 Groveland Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Balto Mays Cem.

DATE OF BURIAL: March 3, 1923

20-UNDERTAKER: Chenoweth & Son

ADDRESS: Charlestown

Spec.—1-10-21—M&T—1500 Bks.

D73271

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 D73271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3359 Beach Ave WARD 13)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L Sunderland

(a) RESIDENCE No. 3359 Beach Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B Sunderland

6 DATE OF BIRTH (month, day, and year) March 4 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Turner

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John A Sunderland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie M. Guery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Mary B Sunderland

(Address) 3359 Beach Ave

Filed 1923 .19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25 1923, to Mar. 1 1923, that I last saw her alive on Mar 1 1923, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Bro Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Toxemia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. F. Kindyall M. D.

3-2-1923 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL March 5 1923

20 UNDERTAKER Chenowith & Son ADDRESS Chestnut Ave

Spec.—1-10-21—M&T—1500 Blks.

D73272

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D73272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 716 N. Curley (St.) (Ward) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Shipley

(a) RESIDENCE No. 716 N. Curley St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Shipley

6 DATE OF BIRTH (month, day, and year) May 23/1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	77.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

006

BIRTHPLACE (city or town) (State or country) Balto Co. Md.

10 NAME OF FATHER Upton A. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mary A Shipley

(Address) 716 N Curley.

Robert F. Harrison,

Burial Permit Clerk

23 , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923.

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923 to March 1, 1923.

that I last saw h alive on March 1, 1923

and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Uremia Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio Cerebral Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible], M. D.

(Address) 800 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount Cemetery

DATE OF BURIAL 3/5 1923.

20 UNDERTAKER Edgeworth Edson

ADDRESS 3667 Edmondson Ave.

Spec.—1-10-21—MAT—1500 Blks.

161818
D73273

HEALTH DEPARTMENT—CITY OF BALTIMORE

51 ✓ D73273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Randall

(a) RESIDENCE NO. 421 N Sprmg St city ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 2yrs yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant JOHNS HOPKINS HOSPITAL (Address) Records

Filed 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to March 1, 1923,

that I last saw her alive on March 1, 1923,

and that death occurred, on the date stated above, at 3.50 a.m.

THE CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis

(duration) yrs. 4½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bugg M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	March 19 23
20 UNDERTAKER Wm Charles B Jones	ADDRESS 1725 Ashland Av

D73274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73274

CERTIFICATE OF DEATH.

181-00

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 N Durham St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Walter Nelson

(Residence in Baltimore: No. 410 N Durham St.; yrs., 5 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	C	

6-DATE OF BIRTH. Nov (Month) 18 (Day) 1922 (Year)

7-AGE. ....yrs. 3 mos.....ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Non
(b) General nature of industry, business, or establishment in which employed (or employer)..... Non

9-BIRTHPLACE, (State or Country). Balt

10-NAME OF FATHER. Walter Garrison

11-BIRTHPLACE OF FATHER, (State or Country). S C

12-MAIDEN NAME OF MOTHER. Celestin Nelson

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore

I-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Celestin Nelson

(Address) 410 Durham St

.....d.....192.....

Registrar.

1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 1 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia (Accident)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema

(Duration) yrs. mos. ds.

(Signed) H. Edwin Blades M. D.
(Coroner)

1923 (Address) 423 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	March 1 1923

20-UNDERTAKER. Mark Robert & Edwin Cleveland ADDRESS 1725 Pennsylvania Ave

D73275

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2621 Greenmount Ave. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian A. Rahter

(Residence in Baltimore: No. 2621 Greenmount Ave. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	widow

6-DATE OF BIRTH. 1869
(Month) (Day) (Year)

7-AGE. 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Landlady
(b) General nature of industry, business, or establishment in which employed (or employer). Rooming House

9-BIRTHPLACE, (State or Country). Somerset, N.J.

10-NAME OF FATHER. (Unknown) Baker

11-BIRTHPLACE OF FATHER, (State or Country). N.J.

12-MAIDEN NAME OF MOTHER. (Unknown) Hurdle

13-BIRTHPLACE OF MOTHER, (State or Country). N.J.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J. Gavin

(Address) 2621 Greenmount Ave

192 Robert P. Harrison,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1st. 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia (Primary)

(Diaghosis verified by Embalmer)

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Culler M. D.
(Coroner.)

3/3/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	March 3, 1923
20-UNDERTAKER.	ADDRESS
Richard H. Cowley	438 E. North ave

Spec.—1-10-21—M&T—1500 Bks.

D73276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73276

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter C. Thomas Jr.

(a) RESIDENCE NO. Belair Rd. Belair Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct, 8, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Walter C Thomas Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Myrtle Bayless

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

JOHNS HOPKINS HOSPITAL

Informant .....

(Address) Local

—1923 Robert T. Harrison,

Filed ....., 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1923 to March 1, 1923

that I last saw him alive on March 1, 1923,

and that death occurred, on the date stated above, at 10.05 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 0 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Colitis, media, suppurative

(duration) 0 yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. B. Mock M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Churchville Md	March 4, 1923
20 UNDERTAKER	**ADDRESS**
Howard K McInnis	Aberdeen

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73277

CERTIFICATE OF DEATH.

3/ D73277

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2646 Boone ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Mason

(a) RESIDENCE. NO. 2646 Boone ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Mason

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 37; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic - 070

(b) General nature of industry, business, or establishment in which employed (or employer): General housework

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): Balto Co Md

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

Informant: Estelle Johnson

Address: 2646 Boone St

Feb 23 1923 Robert F. Hartman Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1922, to Feb 27, 1923, that I last saw her alive on Feb 27, 1923, and that death occurred, on the date stated above, at 1.05 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Thomas, M. D.

Feb 3. 1923 (Address) 1534 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 3/3 1923

20 UNDERTAKER: Samuel J Kennedy

ADDRESS 578 N Eddie

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D73278

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 George ST.: 17 WARD)

REGISTERED No. C 12 D73278

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Willis

(Residence in Baltimore: No. 823 George St.; 57 yrs., 3 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 15, 1870 (Month) (Day) (Year)

7-AGE, 57 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Music Store

9-BIRTHPLACE, (State or Country), Md

10-NAME OF FATHER, Benj F. Willis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Nellie Timms

13-BIRTHPLACE OF MOTHER (State or Country), Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anne Collins

(Address) 823 George

1923 Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 26 1923, to Feb 28 1923, that I saw h[illegible] alive on Feb 27 1923, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) H. S. McCard M. D.

3/2, 1923 (Address) 2005 Hillen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, 3/3, 1923

20-UNDERTAKER Samuel Hemsley — ADDRESS 578 Riddle

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73279

CERTIFICATE OF DEATH.

179 D73279

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Afford ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Massey

(a) RESIDENCE NO. 530 Afford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Massey

6 DATE OF BIRTH (month, day, and year) May 8, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) Westminster
(State or country) Md

10 NAME OF FATHER Wm Massey

11 BIRTHPLACE OF FATHER (city or town) Westminster
(State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Westminster
(State or country) Md

Informant Victoria Massey
(Address) 530 Afford St

1923 . 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1923. to Feb. 28 1923.

that I last saw living alive on Feb. 28th 1923,

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical and microscopic

(Signed) R. Lee Clark M. D.

3/2, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Mar 5 1923

20 UNDERTAKER Samuel T Handley

ADDRESS 5 W Preston

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73280 X90 D73280

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Provident Hospital (Biddle & McCulloh sts.) ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Johnson

(Residence in Baltimore: No. Melley Road Anne Arundel Co. Md. ..... yrs. ..... mos. 5 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	C	

6-DATE OF BIRTH, unknown unknown 1855
(Month) (Day) (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... do

9-BIRTHPLACE, (State or Country), Md

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Harris (Friend)

(Address) 403 N. Eden St

Robert P. Harrison, 1923
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 22 1923, to Feb 28 1923, that I saw him alive on Feb 25 1923, and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Primary)

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(Duration) 20 yrs. ..... mos. ..... ds.

(Signed) R. J. Young M. D.

3/2, 1923 (Address) 1529 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Asbury Cemetary	March 4, 1923

20-UNDERTAKER	ADDRESS
Jos. I. H. Rochester	1413 Jefferson

Spec--12-23-21--E.B.R.S.--400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73281

CERTIFICATE OF DEATH.

90 D73281

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Men's Home St., 19 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. D Chester

(a) Residence No. 1400 W Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 29 1841

7-AGE 82 yrs. 10 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Jacobs Md

10-NAME OF FATHER William Chester

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER, Maria Mitchell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

(Informant) H. W. Dallman

(Address) Walbrook

Robert P. Harrison, 192

Registrar.

23 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 2 23

17- I HEREBY CERTIFY, That I attended deceased from Jan. 15 1923 to March 2 1923

that I last saw h. alive on March 1 1923

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Norwood M. D

Mar 2 23 , 19 (Address) 939 W Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount Cem	Mar 5, 1923
20-UNDERTAKER.	ADDRESS
Geo J. Smith	1532 Hollins St

(Parnell,

D73282 HEALTH DEPARTMENT—CITY OF BALTIMORE 1003

CERTIFICATE OF DEATH. 159-D73282

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 831 Cloney St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude L. Paul.

(Residence in Baltimore: No. 831 Cloney St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widow, Widower or Divorced. (Write the word)
Male	Colored	Single

6-DATE OF BIRTH. Feb 7 1923
(Month) (Day) (Year)

7-AGE. 3 mos 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country) Balto City

10-NAME OF FATHER. Wilson Parnell

11-BIRTHPLACE OF FATHER. (State or Country) Md.

12-MAIDEN NAME OF MOTHER. Lulu Norris

13-BIRTHPLACE OF MOTHER. (State or Country) Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilson Parnell

(Address) 831 Cloney

Robert P. Harrison,
Burial Permit Clerk. Registrar.
1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 1 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Lue

(Duration) yrs. 6 mos. 24 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

(Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	March 3. 1923
20-UNDERTAKER.	ADDRESS
Lamb & Watson	916 Park ave

Spec.—1-10-21—M&T—1500 Blks.

✓ 40 D73283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73283

CERTIFICATE OF DEATH.

Dr. H. K. Grossel
Coroner M.D.

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST. or AVE. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Barnes.

(a) RESIDENCE NO. 658 - W. Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: Black.

5 If Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
27.		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Maryland.

10 NAME OF FATHER Hope Worden.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Rosie Terry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records.
(Address)

23 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27-1923

17 I HEREBY CERTIFY, That I attended deceased from 2/22, 1923, to 2/27, 1923.

that I last saw her alive on 2/27/23, 19....,

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

General - Peritonitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical findings

(Signed) Milton C. Lang, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 3-1-1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Gay

Spec.—1-10-21—M&T—1500 Blks.

D73284

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73284

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Warren Ave ST., 24 WARD)

2-FULL NAME Sarah Elizabeth Llewellyn

(a) RESIDENCE NO. 219 - Warren Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Thomas W Llewellyn

6 DATE OF BIRTH (month, day, and year) June 17- 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .. min.
	67	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) housework 137

(c) Name of employer Self

BIRTHPLACE (city or town)
(State or country) Baltimore Md

10 NAME OF FATHER Irwin Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant Thomas W Llewellyn
(Address) 219 Warren ave

Filed 19 Robert P. Harrison,
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1- 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 25 , 1922 , to March 1 , 1923 , that I last saw her alive on March 1 , 1923 , and that death occurred, on the date stated above, at 10: a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) C E Burton, M. D.

3/2/1923 (Address) 3016 Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Mar 3, 1923
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 N. Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73285

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Glyndon Ave St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Musgrove

(a) RESIDENCE. No. 1211 Glyndon Ave. St., WARD.
(Usual place of abode) Life time (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~Male~~	White	Widowed

5a If married, widowed, or divorced
—~~HUSBAND of~~ (or) ~~WIFE of~~ The Late Alice Musgrove

6 DATE OF BIRTH (month, day, and year) October 10, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Station Master
(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R. R.
(c) Name of employer

BIRTHPLACE (city or town) Baltiomre
(State or country) Maryland

10 NAME OF FATHER William H. Musgrove

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant Alice Schafer
(Address) 1211 Glyndon Ave.

923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1- 1923

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to March 1, 1923.
That I last saw h[illegible] alive on March 1, 1923.
and that death occurred, on the date stated above, at 9 4 m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) yrs. 3 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mayland Dreen M. D.
, 19 (Address) 111 Mad Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 3, 1922

20 UNDERTAKER Harry H. Witzke

ADDRESS 1521 W Lombard

Spec.—6-9-19—H. F. Co.—1000 Blks.

D73286

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73286

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 E. 30th, ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Brumble

(a) RESIDENCE. NO. 319 E. 30th, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma F. Brumble

6 DATE OF BIRTH (month, day, and year) April 8th, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Machinery

(c) Name of employer Nathan Mnf'g Co.

BIRTHPLACE (city or town) Renova Penna.
(State or country)

10 NAME OF FATHER William Brumble

11 BIRTHPLACE OF FATHER (city or town) Fayetteville
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Inez Crandall

13 BIRTHPLACE OF MOTHER (city or town) Ridgeway
(State or country) Penna.

Informant Mrs Emma F. Brumble
Address) 319 E. 30th St

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1922 to March 2, 1923 that I last saw h alive on March 1st, 1923, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) — yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Apr. 1922

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jefferies Buell M. D.

3/2 1923 (address) 2844 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 5th 1923
20 UNDERTAKER	ADDRESS
Peter Lee	1723 N. Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

D73287

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73287

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1613 E. Oliver St. (WARD) 8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Smith

(a) RESIDENCE NO. 1613 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian J. Smith

6 DATE OF BIRTH (month, day, and year) Oct 14, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Fred'k Gebhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Baum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Christian J. Smith

(Address) 1613 E. Oliver St

Filed ... 19...

1923

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 12, 1923, to March 1, 1923, that I last saw h[illegible] alive on Feby 28, 1923, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Chronic Nephritis Unknown

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'Neill, M. D.

3/2, 1923 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Mar 5 1923

20 UNDERTAKER J. C. Waidfield — ADDRESS 914 Gruhmont Ave

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73288

D73288

CERTIFICATE OF DEATH. 1 23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2136 Herbert ST., 15th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson A. Spicer.

(a) RESIDENCE NO. 2136 Herbert ST., 15th WARD —

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? 45 yrs. 9 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Spicer.

6 DATE OF BIRTH (month, day, and year) Sept 18-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45 yrs	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Gen. Chem. Co.

(c) Name of employer General Chem. Co. Baltimore

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Charles C. Spicer.

11 BIRTHPLACE OF FATHER (city or town) Cross Roads (State or country) Harford County.

12 MAIDEN NAME OF MOTHER Sophia Spicer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

Informant Esther Spicer

(Address) Govan Md.

Filed 1/3 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2— 1923

17

I HEREBY CERTIFY, That I attended deceased from 2-20— 1923, to 3-2— 1923.

that I last saw h[illegible]live on 3-2— 1923,

and that death occurred, on the date stated above, at 1135 a. m.

The CAUSE OF DEATH* was as follows: Encephalitis Lethargica?

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Grippe + Arsenic.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Will perform.

What test confirmed diagnosis?

(Signed) A. Peters, M. D.

3-2 1923 (Address) 2202 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mch 5 1923
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	W North Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73289

D73289

CERTIFICATE OF DEATH.

X117

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathryn Gelbing McStewart

(a) RESIDENCE No. 2435 Maryland Ave ST., WARD Woodstock Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodstock Md

10 NAME OF FATHER Madison H. McStewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trenton N. J.

12 MAIDEN NAME OF MOTHER Irene Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Woodstock Md

Informant Sarah Kitchen

(Address) 313 E. Monte Ave

Filed 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 31st, 1923, to March 2nd, 1923, that I last saw h[illegible] alive on March 2nd, 1923, and that death occurred, on the date stated above, at 6.07 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis & intestinal Obstruction (Which followed operation for appendicitis & salpingectomy (Organ unknown)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — if not at place of death? at Franklin Sq. Dec '22

Did an operation precede death? Yes Date of Feb 22, 1923 at 4.2 P.M.

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) L. B. Newbock, M. D.

Mar 2, 1923 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Cem. DATE OF BURIAL Mar. 4 1923

20 UNDERTAKER Elston Sons ADDRESS Ellicott City

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73290

CERTIFICATE OF DEATH.

44

D73290

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Homestead ST., 9 WARD)

2-FULL NAME Carrie H. Garrett

(a) RESIDENCE NO. 622 Homestead ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Howard W. Garrett

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
53	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work (Wife)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Petersburg Va
(State or country)

PARENTS

10 NAME OF FATHER William H. Meredith

11 BIRTHPLACE OF FATHER (city or town) Petersburg
(State or country) Va.

12 MAIDEN NAME OF MOTHER Susana Smith

13 BIRTHPLACE OF MOTHER (city or town) Petersburg
(State or country) Va.

14 Informant Howard W. Garrett
(Address) 622 Homestead Ave

15 Filed ..... 19 ..... Registrar
Burial Permit Clerk.

R 3-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1922, to March 2nd, 1923, that I last saw h[illegible] alive on March 1st, 1923, and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. 3 mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? yes Date of Jan 20th 1923

Was there an autopsy? no

What test confirmed diagnosis? Microscopic & Clinical

(Signed) L. L. Gordy, M. D.

, 19 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: 3/5 19 23

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-00 D73291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 570 W. University Parkway ST. | 17 WARD)

2-FULL NAME Frank Briscoe Bready

(a) RESIDENCE NO. 570 W. University Parkway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelle Sein

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER David Franklin Bready

11 BIRTHPLACE OF FATHER (city or town) Montgomery Co.,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha A. C. Yewell

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel
(State or country) Maryland

14 Informant Mrs. Adelle Bready
(Address) 570 W. University Parkway

15 Filed 3-3-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/16/22, 19 ... to 3/1/23, 19 ..., that I last saw him alive on 3/1/23, 19 ..., and that death occurred, on the date stated above, at 9:0 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Alcoholism & Hyalin Blood Pressure. (duration) ... yrs. 9 mos. ... ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. B. Coombs M. D.

(Address) Arlington.

*State (1) Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/3 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73292 D73292

CERTIFICATE OF DEATH.

REGISTERED NO. 8162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 Ellwood Place ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Johnson

(a) RESIDENCE. No. 1901 Ellwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-1-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Johnson Thos E

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Leona Hofmeyer

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Thos. Johnson
(Address) 90 Ellwood Place

15 Filed 19 Robert P. Harrison, Registrar

3-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2- 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 2, 1923, that I last saw h[illegible] alive on March 2, 1923 and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? at birth

(Signed) Jeanne Green, M. D.

, 19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	3/3/1923
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1938 E. Lafayette Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital 5 ST.; WARD)

REGISTERED No. C 66

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F Ryan

(Residence in Baltimore: No. Leeds House St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, Nov. (Month) 9th (Day), 1873 (Year)

7-AGE, 49 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Edward J. Ryan

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Coughlein

(Address) 113 S. Broadway

15- Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk,

MAR 3 - 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mr. 27 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Exhaustion

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

(Address) 436 Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Mch. 5th, 1923

20-UNDERTAKER Lilly + Zeiler — ADDRESS 4038 Wolfe St

R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73294

CERTIFICATE OF DEATH.

101-00 D73294

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 S. Ellwood Ave ST., 1 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Fredericka Remlein

(a) RESIDENCE NO. 609 S. Ellwood Ave ST., 1 WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John D. Remlein

6 DATE OF BIRTH (month, day, and year) April 14 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establisiment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wilhelm Youmsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Gibbon Daughter
(Address) Eastern Ave Road Edgewood

15 Filed MAR 3 - 1923 Robert P. Harrison, Registrar
Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1923, to Feb 28, 1923, that I last saw h[illegible] alive on Feb 28, 1923, and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Emphysema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physicians

(Signed) Hans A Fischer, M. D.

, 1923 (Address) 332 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Mch 5 1923
20 UNDERTAKER	ADDRESS
Lilly - Zeiler	4033 Belair Rd.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73295

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 9 WARD)

2-FULL NAME Mary M. Keys

(a) RESIDENCE NO. St. Elizabeth's Home ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	33 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) West Virginia

PARENTS

10 NAME OF FATHER Geo. Keys

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie Tucker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West Virginia

14 Informant Hospital Records
(Address) M.T.H.

15 Filed 3-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1923, to March 2, 1923, that I last saw her alive on March 2, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Delagliacca M. D.

3-2-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 3-5-23

20 UNDERTAKER Wright H. Holland

ADDRESS 1631 Harford

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

3-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73296 D73296

CERTIFICATE OF DEATH. 31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 N Stricker ST., 15 WARD)

2-FULL NAME Margorie Jackson

(a) RESIDENCE NO. 1525 Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 2-1908

7 AGE 15 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) School Pupil

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Va

PARENTS

10 NAME OF FATHER James Jackson

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Md

12 MAIDEN NAME OF MOTHER Otelia Brown

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Va

14 Informant James Jackson (Address) 1332 Druid Hill Ave

15 MAR 3-1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/18, 1923, to 3/2 -, 1923.

that I last saw h- alive on 3/2 -, 1923,

and that death occurred, on the date stated above, at 11 00 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis -

about 2 mos

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Rhett, M. D.

3/3, 1923 (Address) 2134 D St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Pond Va — DATE OF BURIAL Mar 3 1923

20 UNDERTAKER Geo H A Gibson — ADDRESS 513 Fawn St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73297 ✓ D73297

CERTIFICATE OF DEATH.

33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D73297

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5332 Woodyla ST.: 15 WARD)

2-FULL NAME Richard E Hughes

(a) RESIDENCE. NO. 1332 Woodyla ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Boy Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 27 1904

7 AGE 18 Years 5 Months 3 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas E Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mable Hughes
(Address) 1332 Myrtle ave

15 Filed MAR 3 - 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/23 19

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1922, to Mar 1, 1923, that I last saw him alive on Mar 1, 1923, and that death occurred, on the date stated above, at 9:20 m.

The CAUSE OF DEATH* was as follows:
Intestinal Tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gastritis
(duration) 1 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm P Boykin, M. D.
, 19 (Address) 1618 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cem	3-6 1923
20 UNDERTAKER	ADDRESS
Troy H Holland	1651 Division

Hilgus

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied.

Spec.—8-24-14—M. & T.—2000 Em.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73298

CERTIFICATE OF DEATH.

101-001 D73298

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Florence Cotterton Mat. St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. Wheelton

(Residence in Baltimore: No. Committed to Florence Cotterton Mat. St.; ..... yrs., 10 mos. 11 da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	

6-DATE OF BIRTH, April 19th, 1922
(Month) (Day) (Year)

7-AGE, ... yrs. 10 mos. 11 da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 42 Mason st Brooklin Md

PARENTS.

10-NAME OF FATHER, Leonard Wheelton

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record of Flo Cot Missing

(Address) 2370 Eliza St City

15- Filed ....., 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

3-1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 18 1923, to March 2 1923, that I saw him alive on March 1 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

..... (Duration) ..... yrs. ..... mos. 2 da.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) Edward Faldeen M. D.

Mar. 2, 1923 (Address) 1014 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 1 mos. 13 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 42 Mason st Brooklin Md

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Mar. 3, 1923

20-UNDERTAKER John F. Denny — ADDRESS 715 Light St

D73299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X/66 D73299

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 1 Thames Av Smith St 13 WARD)
2 FULL NAME 2800 Parkwood ave
(Residence in Baltimore: No. 2800 Parkwood ave.)

REGISTERED No. C—

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 1 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: Male
4 COLOR OR RACE: white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word): married
6 DATE OF BIRTH: November (Month) ..... (Day), 1858 (Year)
7 AGE: 64 yrs. 8 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.
8 OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Insurance
9 BIRTHPLACE (State or Country): Cross Roads York Co. Penna
10 NAME OF FATHER: Sampson Smith
11 BIRTHPLACE OF FATHER (State or Country): Penna
12 MAIDEN NAME OF MOTHER: Ellen Mc. Allister
13 BIRTHPLACE OF MOTHER (State or Country): Penna
PARENTS.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward M. Norris
(Address) 2800 Parkwood ave

15
Filed MAR 3 1923
Robert F. Harrison
Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 3, 1923 (Month) (Day) (Year)
17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) did find that said deceased came to h... d... on the day stated above.
THE CAUSE OF DEATH* was as follows:
Coronary Thrombosis
Hemiplegia 1 hr 30 Min.
J. Sidney Hubbard
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm. H. Morrison M. D.
(Coroner)
Mar 3 1923 (Address) 1392 Bolton st.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Emmitsburg Md.

19 PLACE OF BURIAL OR REMOVAL: Stewartstown Penna
DATE OF BURIAL: March 3 1923
20 UNDERTAKER: Chas. P. Black
ADDRESS: 742 W. North ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

H

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73300

D73300

CERTIFICATE OF DEATH.

4 + 135

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Monaghan

(a) Residence No. Confederate Home Pikesville Md. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Unknown

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1836

7-AGE. 87 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter 50

(b) General nature of industry, business, or establishment in which employed (or employer) Quarter 0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS

10-NAME OF FATHER, Unknown?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Hospital Record

(Address)

15- Robert P. Harrison, Registrar.

3-1923 19? Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 1 '23

17- I HEREBY CERTIFY, That I attended deceased from Feb 24 1923 to Mar 1 1923

that I last saw him alive on Mar 1 1923

and that death occurred, on the date stated above, at 11 20 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Erysipelas

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym & Signs

(Signed) W. H. Keating M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Charles Cemetery Pikesville

DATE OF BURIAL, March 5 1923

20-UNDERTAKER. Wm. L. Black

ADDRESS 1417 W. Baltimore ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73301

CERTIFICATE OF DEATH.

90 D73301

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1352 Fremont ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Dorsey

(Residence in Baltimore: No. 1352 Fremont St. 25 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ..., 1847
(Month) (Day) (Year)

7-AGE, 76 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 70

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Raymond Dorsey (Son)

(Address)..... 1352 Fremont St.

15-

Filed..... Robert P. Harrison.....
Registrar.

3 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1923, to March 1 1923, that I saw h[illegible] alive on March 1 1923, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Cumpston M. D.

March 2, 1923. (Address) 1602 Pulaski Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, March 3, 1923

20-UNDERTAKER James N. Davis — ADDRESS 1313 Division

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73302

CERTIFICATE OF DEATH.

10 D73302

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 S Bond ST., V WARD)

2-FULL NAME Steve Siedlik

(a) RESIDENCE No. 829 S Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
		7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ignatius Siedlik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Krystek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ignatius Siedlek (Address) 829 S Bond St

15 Filed 3-1923 19.. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 2, 1923

that I last saw h— alive on March 2, 1923

and that death occurred, on the date stated above, at 5.38 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) — yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 3 1923

20 UNDERTAKER	ADDRESS
John McWeber	1803 Bank St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

NK—THIS IS A PERMANENT RECORD. Every item of Infor- AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPA- ngs on back of certificates.

Spec.-1-10-21-M&T-1500 Blks.

D73303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D73303

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #8-West-Read-St. ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. EMMA NICODEMUS WARFIELD

(a) RESIDENCE NO. #8-West-Read-St. ST., 11 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? 64 yrs. 8 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gov. Edwin Warfield

6 DATE OF BIRTH (month, day, and year) June-12-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Josiah C. Nicodemus

11 BIRTHPLACE OF FATHER (city or town) Waynesboro
(State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Montandon

13 BIRTHPLACE OF MOTHER (city or town) Waynesboro
(State or country) Penna.

14 Informant Edwin Warfield, (Son)
(Address) Woodbine P.O., Md.

15 Filed ....., 19..... Robert P. Harrison, Registrar
MAR 3-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922, to March 2, 1923, that I last saw h[illegible] alive on March 1, 1923, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 4 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Liver

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Northern

Did an operation precede death? yes Date of March 1919

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) Edwin Warfield, M. D.

3/1, 1923 (Address) 605 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cherry Grove, Howard Co. Md — DATE OF BURIAL: Mar-4-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

...mation should be carefully supplied. AGE should be stated EXACT
CAUSE OF DEATH in plain terms, so that it may be properly classified
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D73304 D73304

CERTIFICATE OF DEATH

41

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1420 N. Eden) ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Francis A. Deifpert

(Residence in Baltimore: No. 1420 N. Eden St.; ..... yrs. ..... mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Mulatto

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: February 14 (Month), 1923 (Year)

7 AGE: ..... yrs. ..... mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Francis J. Deifpert

11 BIRTHPLACE OF FATHER (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary A. Shanahan

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Francis J. Deifpert
(Address) 1420 N Eden St

15 Robert P. Harrison,
MAR 3 - 1923, 191 .....
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 3 (Month), (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to Mar 3, 1923, that I saw him alive on Mar 2, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Streptococcus Infection

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY): toxemia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed), H. G. Brutes M. D.

Mar. 3, 1923 (Address) 634 Gorsuch ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Mar 5, 1923

20 UNDERTAKER: Henry Hoeck Son ADDRESS: 1301 E Eager

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73305 ✓ 101-00 D73305

D73305

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1846 N Wolfe St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John W Pierce

(a) Residence No.... 1846 N Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Pierce

6-DATE OF BIRTH (month, day and year) May 1854

7-AGE, 67 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Orange Count. Va

PARENTS.

10-NAME OF FATHER, John W Pierce

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Orange Co Va

12-MAIDEN NAME OF MOTHER Amanda Tomlin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Orange Co Va

14- (Informant) Mrs. Mary E. Pierce

(Address) 1846 N Wolfe St

15- Mar 3 1923 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 1/23

17- I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to Mar 1, 19 23, that I last saw h. alive on Mar 1, 19....., and that death occurred, on the date stated above, at 5.50 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas A Duttrope, M. D.

3/2, 1923 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Orange Count Va | DATE OF BURIAL, March 4, 1923

20-UNDERTAKER, William Cook Sons & Nathan | ADDRESS

In plain terms, so that it may be properly classified. [illegible] instructions on back of certificate.

3-1923

Dr Fenton

D73306

HEALTH DEPARTMENT—CITY OF BALTIMORE

89

D73306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Removed died at 15

City of BALTIMORE: (No. Franklin Square Hospital St. Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Clayton

(Residence in Baltimore: No. 2941 Westwood Ave St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SUPPLY Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Nov 5 1868
(Month) (Day) (Year)

7-AGE, 54 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Clayton Bros

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER Theodore Clayton

11-BIRTHPLACE OF FATHER, (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Mary Keyser

13-BIRTHPLACE OF MOTHER, (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Matilda Clayton
(Address) 2941 Westwood

15-

APR 3 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptus Coronary Artery (Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D.
(Coroner.)

March 3 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	3/6 1923
20-UNDERTAKER Wm Cook	ADDRESS 502 E North

Burial Permit Clerk.

IMPORTANT. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73307

CERTIFICATE OF DEATH

101-00 D73307

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 N. Chapel St., WARD) 8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Diehl

(a) RESIDENCE NO. 1701 N. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Single

6 DATE OF BIRTH (month, day, and year) Nov 15 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist

(b) General nature of industry, business, or establishment in which employed (or employer) B+O R.R. 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs Schielzing

(Address) 1901 N. Chapel

15 Filed 3-1923, 19 Robert E. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 19 23, to March 19 23.

that I last saw him alive on March 19 23,

and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Frazier, M. D.

, 19 (Address) 140 W. Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL May 5 1923

20 UNDERTAKER Wm. Leask — ADDRESS 502 E. Monument

NOTICE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

Jacob Spangler. 73308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73308

CERTIFICATE OF DEATH. X 118-002 D73308

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lehmont Home ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Spangler.

(a) RESIDENCE NO. Lehmont Home ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? 57 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Spangler

6 DATE OF BIRTH (month, day, and year): About

7 AGE — Years: 57 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Railroad

(b) General nature of industry, business, or establishment in which employed (or employer): Conductor

(c) Name of employer: B. & O. R.R. Co

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Jesse T Wade

(Address): Kenova W Va

15 MAR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 3 1923

17

I HEREBY CERTIFY, That I attended deceased from 2/23/23, 19..... to 3/2/23, 19.....

that I last saw him alive on March 2nd, 1923,

and that death occurred, on the date stated above, at 11.55 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 2/23/23

Was there an autopsy? .....

What test confirmed diagnosis? Operative Findings

(Signed) H. G. Rice, M.D.

, 19 (Address) Lehmont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kenova W Va — DATE OF BURIAL: March 3 1923

20 UNDERTAKER: William Lee — ADDRESS: 502 E Main Ave

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-20-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72309 — 161-001 — D72309

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 55 White Ave ST., 27 WARD) Hamilton

2-FULL NAME Infant of Helen & Henry Alsruhe

(a) RESIDENCE NO. 55 White Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 28 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Alsruhe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Irvington New Jersey

12 MAIDEN NAME OF MOTHER Helen L. Kirchner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Henry Alsruhe
(Address) 55 White Ave

15 Filed MAR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/28, 1923, to 3/3, 1923, that I last saw h[illegible] alive on 3/3, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth (6 mos)

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) D. H. Berman M.D., M. D.

3/3 1923 Address 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 5 1923
20 UNDERTAKER	**ADDRESS**
Henry Hovell Son	1301 E Eager St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73310

CERTIFICATE OF DEATH.

31 D73310

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hospital School ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wieczynski

(Residence in Baltimore: No. 223 South Washington St. St.; ....yrs.. ....mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December (Month) 23 (Day), 1911 (Year)

7-AGE, 11 yrs. 2 mos. 6 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank Wieczynski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Agnes Zamiarski

13-BIRTHPLACE OF MOTHER (State or Country), U. S. A.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... E. Lenhard

(Address)..... Ch. H.

15-

FILED MAR 4 1923 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 3 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9, 1917, to March 2, 1923, that I saw him alive on March 2, 1923, and that death occurred, on the date stated above, at 1.05 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Hip
Amputation of Thigh

..... (Duration) 4 yrs. 7 mos. ....da.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....da.

(Signed) E. E. Lenhard M. D.

March 2, 1923. (Address) Childrens Hosp. School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 11 mos. ....da. In the State 11 yrs. 2 mos. ....da.

Where was disease contracted, if not at place of death? at home

Former or usual residence 223 S. Washington St.

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary. DATE OF BURIAL, March 5, 1923

20-UNDERTAKER William Fiallowski ADDRESS 1618 Eastern ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73311

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Hanover ST.: 23 WARD)

2-FULL NAME Caroline Wolf.

(a) RESIDENCE. No. 1513 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Wolf

6 DATE OF BIRTH (month, day, and year) Nov 13th 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo. H. Knapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Emma Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Crout, Daughter
(Address) 1513 Hanover St.

15 Filed MAR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from February 24th, 1923, to March 2nd, 1923, that I last saw her alive on March 2nd, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Amalia E Funk, M. D.

. 19 (Address) 1717 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Pine	March 5 1923
20 UNDERTAKER	ADDRESS
B Schloman, Son	Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73312

CERTIFICATE OF DEATH.

129 D73312

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Miller

(a) RESIDENCE NO. 908 S. Third St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Miller

6 DATE OF BIRTH (month, day, and year) Mar 12th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Diamond

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Anna West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mr John Miller

(Address) 908 S Third St

15 FILED MAR 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1923 to March 2, 1923

that I last saw h[illegible] alive on March 2, 1923

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 2 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John G. O'Connor, M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mathia's Cem	Mar 5 1923
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2040 Eastern Av

CAUSE OF DEATH should be stated EXACTLY. AGE should be carefully supplied. Every item of information should be carefully recorded. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73313

CERTIFICATE OF DEATH

100-001 D73313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 N Caroline ST. 5 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Solomon

(a) RESIDENCE NO. 436 N Caroline St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 38 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Solomon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sam Fichter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Russia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Balto.

15 Filed MAR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 11, 1923, to March 4, 1923, that I last saw h[illegible] alive on March 4, 1923, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) ... yrs. mos 24 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) G. L. Hornstein, M. D.

3/4, 1923 (Address) 723 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Friendship Cem	March 4 1923
20 UNDERTAKER	ADDRESS
Jos. Lewis,	1439 E Balto St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

98 D73314

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3408 Holmes Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Shane

(a) RESIDENCE No. 3408 Holmes ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER Edward Shane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Lipsitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto st

15 Filed MAR 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1923, to March 3, 1923, that I last saw h[illegible] alive on March 3, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Laryngismus Stridulus

(duration) 6 hrs.

CONTRIBUTORY (Secondary) Bronchitis

(duration) 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Feb. 26

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. F. Bayless, M. D.

3/4 1923 (Address) 710 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Courthouse Ave. DATE OF BURIAL March 4 1923

20 UNDERTAKER Jack Lewis, ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spasmodic Croup

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73315 129 D73315

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 23 WARD)

2-FULL NAME Mrs Fanny Levin

(a) RESIDENCE NO. 1434 S Eden ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Levin

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE 62 Years | Months | Days | If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mendel Smilk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Leah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levin (Address) 1434 Eden St

15 FILED MAR 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2/1923

I HEREBY CERTIFY, That I attended deceased from Jan 24 19 23 to March 2 19 23

that I last saw h alive on March 2 19 23

and that death occurred, on the date stated above, at 2. P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

Bronchio Pneumonia

(duration) yrs. 1 mos. 1 da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 3/4 1923

20 UNDERTAKER Jack Levin

ADDRESS 1434 Eden St

Spec.—1-10-21—M&T—1500 Blks.

D73316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D73316

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Bolton St ST., 14 WARD)

2-FULL NAME Annie Tovar Bond

(a) RESIDENCE NO. 1402 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Wht	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No Occupation

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Dr Thomas E Bond

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Annie Morris

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country)

14 Informant Frank Bond (Address) 3204 Walbrook Ave

15 MAR 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1923, to Mar 2nd 1923, that I last saw her alive on Mar 2nd, 1923, and that death occurred, on the date stated above, at 5.00 a. m.

The CAUSE OF DEATH* was as follows:

Malignant Neoplasm of Stomach with General Metastases

(duration) about yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examin.

(Signed) S. A. Rodeler, M. D.

, 19 (Address) 3101 Clifton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	March 5 1923

20 UNDERTAKER John B. Spence ADDRESS 1328 N. Caroline

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73317

CERTIFICATE OF DEATH.

129

D73317

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 Ashburton ST.: 16 WARD)

2-FULL NAME William B. Townsend.

(a) RESIDENCE. No. 600 Ashburton ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1903.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John M. Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E Belt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant (Address) Mary E. Townsend 600 Ashburton St.

15 Filed MAR 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923.

17

I HEREBY CERTIFY, That I attended deceased from July 31, 1922, to March 3, 1923, that I last saw h[illegible] alive on March 3, 1923; and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Chronic Endocarditis.
Chronic Parenchymatous Nephritis

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Mitchell, M. D.

(Address) 290 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	March 6 1923
20 UNDERTAKER Robert S. Little	ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73318

CERTIFICATE OF DEATH.

74-001 D73318

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 N. Carey ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward L. Haynie

(a) RESIDENCE No. 632 N. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Haynie

6 DATE OF BIRTH (month, day, and year) Feb 28 1841

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
82		3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Va

PARENTS

10 NAME OF FATHER Thaton Haynie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Clarence Barrett.
(Address) 632 N. Carey St.

15 Filed MAR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 1923, to Mch 3 1923, that I last saw h[im] alive on Mch 3 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chron. Endocarditis (Mitral Regurgitation)

(duration) Unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

3/4, 1923 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairport Co Mch 4	1923
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 E. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73319 ✓ 129 D73319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3016 Barclay St. ST. 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily A. Rowe

(a) RESIDENCE NO. 3016 Barclay St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER John Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Cloudsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Charles E. Gray

(Address) 3016 Barclay St.

15 Filed MAR 4 - 1923 ROBERT M. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25 1923, to March 2 1923.

that I last saw her alive on March 2, 1923.

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Hypostatic Pneumonia)

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Par. Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Machen, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hereford Baptist Cem. (Balto Co)	March 4 1923
UNDERTAKER	ADDRESS
Horace H. Burgee	363 Hallo Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73320

CERTIFICATE OF DEATH.

101-00/D73320

1-PLACE OF DEATH

City of BALTIMORE: (No. 5135 Resistertown Rd St. 28 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Elizabeth V. Steffe

(a) Residence No. 5135 Resistertown Rd St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the Word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 24-1918

7-AGE, ... (5) yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Daniel G Steffe

11-BIRTHPLACE OF FATHER (city or town) Balt Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Eliz. V. Master

13-BIRTHPLACE OF MOTHER (city or town) Balt Md
(State or Country),

14-

(Informant) Daniel G Steffe

(Address) 5135 Resistertown Rd

15-

Filed MAR 4 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 1-23

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 19 23 to March 1 19 23

that I last saw h.. alive on March 1 19 23,

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm D Baker, M. D.

, 19 (Address) 4834 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine. DATE OF BURIAL, Mar 5, 1923.

20-UNDERTAKER, William Carl Sons ADDRESS Park Heights Ave

instructions on back of certificates.

...ified. Exact statement of OCCUPATION is very important. See ...ould state CAUSE OF DEATH ... it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73321

CERTIFICATE OF DEATH.

74-00/D73321

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Park ave ST., 14 WARD)

2-FULL NAME Jennie Watkins

(a) RESIDENCE No. 1604 Park ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr Edgar Allen Poe Jr

9 BIRTHPLACE (city or town) (State or country) East N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar Allen Poe Jr (Address) 1604 Park Ave

15 Filed MAR 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to March 2 1923, that I last saw h.. alive on March 1, 1923, and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ? yrs. ? mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Indigestion & Expension (duration) ? yrs. ? mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Edd Fuller, M. D.

3/3, 1923 (Address) 476 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL MAR 4 1923

20 UNDERTAKER Samuel P Langley

ADDRESS 578 N Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

197 D73322

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Nww Hospital St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Wm Baker

(Residence in Baltimore: No. 936 Argyle St.; yrs., mos. ds.) 18 — —

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. (Month) Unknown (Day) (Year) 1896

7-AGE. 27 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundress
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country) Atlanta Georgia

PARENTS.

10-NAME OF FATHER. Rodeard Baker

11-BIRTHPLACE OF FATHER. (State or Country) Atlanta Georgia

12-MAIDEN NAME OF MOTHER. Elizabeth Smith

13-BIRTHPLACE OF MOTHER. (State or Country) Athens Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rodeard Baker

(Address) 936 Argyle Ave

15- Filed MAR 4 - 1923 19?

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Feb. (Day) 28 (Year) 23

17- I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereof; and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicide

Gun Shot wound

(Duration) Instt yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) 5 days yrs. mos. ds.

(Signed) T. Roland Blake M. D.

(Coroner) Mar 3 1923 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Atlanta Georgia — DATE OF BURIAL. MAR 4 1923

20-UNDERTAKER. Samuel D Mayerley — ADDRESS 578 N Biddle St

DEATH CERTIFICATE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73323

CERTIFICATE OF DEATH.

11-001 D73323

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 Mura ST., 8 WARD)

2-FULL NAME Harry C. Maxwell Jr

(a) RESIDENCE NO. 2218 Mura ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 4th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Harry C. Maxwell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Lena Schroeder

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Harry C Maxwell
(Address) 2218 Mura st

15 MAR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2 1923

17 I HEREBY CERTIFY, That I attended deceased from
Feb 25, 1923 to 3-2, 1923
that I last saw him alive on 3-2, 1923
and that death occurred, on the date stated above, at 4.15 a. m.
The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Ryneska M. D.

3-2-23 (Address) 600 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 5th 1923
20 UNDERTAKER	ADDRESS
George L Schilling & Sons	1126 E Monument St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied. Every item of information should be carefully supplied.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73324 44 D73324

CERTIFICATE OF DEATH.

D73324
1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2804 Parkwood ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Volker

(a) RESIDENCE NO. 2804 Parkwood ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John Volker

6 DATE OF BIRTH (month, day, and year) Nov 18th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Diehm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Birchoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Volker
(Address) 2804 Parkwood ave

15 MAR 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 2, 1923, that I last saw h[illegible] alive on March 1, 1923, and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(duration) yrs. 6 or 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible physical signs and [illegible]

(Signed) C. F. S. Hemmeter, M. D.

March 2 1923 (Address) 22-6 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel Lutheran Cem	Mar 5th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1166 E Monument

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73325

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Bennett Place ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Braydon, Jr.

(a) RESIDENCE. No. same ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widower

6 DATE OF BIRTH (month, day, and year) Oct 5. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 15

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cato md

PARENTS

10 NAME OF FATHER Wm. W. Braydon

11 BIRTHPLACE OF FATHER (city or town) Cato (State or country)

12 MAIDEN NAME OF MOTHER Catherine ...tal

13 BIRTHPLACE OF MOTHER (city or town) Cato Md (State or country)

14 Informant Frank M. Braydon
(Address) 1011 Bennett Place

15 MAR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 2 23 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1919, 19, to Mar 2 1923, 19, that I last saw h... alive on Mar 2 23, 19, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

chronic myocarditis and arterio-sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. R. Kinnie, M. D.

r 3. 23 (Address) 619 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	3-5-1923
20 UNDERTAKER H. C. Brauning Son	ADDRESS 517 N. Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73326

D73326

CERTIFICATE OF DEATH.

X 11-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 Whitmore Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry S. Fitch Wheler

(a) RESIDENCE NO. Hagerstown Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 month ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Emsey Wheler

6 DATE OF BIRTH (month, day, and year) Nov 10 - 1868

7 AGE 54 Years 3 Months 21 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) Western Union Telegraph Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Finksburg Carroll Co Md

PARENTS

10 NAME OF FATHER John H Wheler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Emma B. Fitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) W. H Wheler Son Hagerstown Md.

15 Filed MAR 4 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/23

17 I HEREBY CERTIFY, That I attended deceased from 3/1/23, 19 to 3/1/23, 19, that I last saw him alive on 3/1/23, 19, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Flu,

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1733 Thomas Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) H Bolton Wyatt M. D.

3/5/23 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md — DATE OF BURIAL: March 5 1923

20 UNDERTAKER: Mr W. Gawthrop — ADDRESS: 2839 Rayner Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73327 ✓ D73327

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 E. Biddle St ST., 11 WARD)

2-FULL NAME Edgar Bressler Hunt

(a) RESIDENCE NO. 414 E. Biddle St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Annie H. Kelly

6 DATE OF BIRTH (month, day, and year) Jan 8-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Md

PARENTS

10 NAME OF FATHER Francis Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Bressler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Elizabeth Hunt
(Address) 1913 Greenmount Ave

15 MAR 4-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17

I HEREBY CERTIFY, That I attended deceased from June, 1922, to Mar 2, 1923.

that I last saw him alive on March 2, 1923,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2yrs. Approximately mos. ... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Gustav H. Wolferth M. D.

Mar 3 1923 (Address) 1120 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL March 5, 1923

20 UNDERTAKER E. Le Roy Stifflen — ADDRESS 1755 E. Monument ave

CAUSE OF DEATH in plain terms, so that AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73328 ✓ D73328

CERTIFICATE OF DEATH. 111-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf ST., 6 WARD)

2-FULL NAME Mr. Harry N. Curry

(a) RESIDENCE NO. 405 N. Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Bertha Curry

6 DATE OF BIRTH (month, day, and year) Feb 13 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	41	X	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad 173

(c) Name of employer Penn R.R. Baltimore

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Newman B Curry

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ida Sargent

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Bertha Curry Wife
(Address) 405 N. Robinson St

15 MAR 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to Mar. 2, 1923, that I last saw h in alive on Mar. 2, 1923, and that death occurred, on the date stated above, at 9:50 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage from Gastric ulcer.

(duration) X yrs. X mos X ds.

CONTRIBUTORY (Secondary) Gastric ulcer

(duration) ..... yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 14/23.

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Richard S. Coolidge M. D.

, 19 (Address) U. of M.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Mch 4 1923

20 UNDERTAKER Milton H. Jones ADDRESS 414 N. Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73329 57 D73329

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Boone ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary O'Malley

(a) RESIDENCE NO. 2111 Boone ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward O'Malley

6 DATE OF BIRTH (month, day, and year) Aug 15-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Giles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick O'Malley

(Address) 2111 Boone St

15 FILED MAR. 4 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1923, to March 2, 1923, that I last saw h[illegible] alive on March 1, 1923, and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:

Sepsis due to gangrene of foot.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary

(Signed) Benj. D. Hamblin M. D.

3/3, 1923 (Address) 216 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/5 1923

ADDRESS

20 UNDERTAKER Chas F. Evans & Son 1180 W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73330

CERTIFICATE OF DEATH.

89 D73330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Park Heights Ave & Carroll Rd (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon S. Wurzburger

(a) RESIDENCE No. Pk Heights & Carroll Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Wurzburger

6 DATE OF BIRTH (month, day, and year) Jany 13/1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
54	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Simon Wurzburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant S. Wurzburger

(Address) Pk Heights & Carroll Rd

15 MAR 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Mar 3, 1923, that I last saw him alive on Mar 2, 1923, and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Edwin G. Krieger, M. D.

3/3. 1923 (Address) 1138 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto-Hebrew DATE OF BURIAL Mch 5 1923

20 UNDERTAKER David Bondheim ADDRESS 1114 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78331

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

145-003 D78331

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 5011 Beaverwood Ter St.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie Pearl Parker

(Residence in Baltimore: No. 5011 Beaverwood Ter St.; 5 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
F	B	Married

6-DATE OF BIRTH ..... (Month) ..... (Day) 1876 (Year)

7-AGE 33 yrs ..... mos ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Md

PARENTS

10-NAME OF FATHER Charles Stanton

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Ant Anne

13-BIRTHPLACE OF MOTHER (State or country) Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Stanton Stockton D Parker

(Address) 5011 Beaverwood Ave

MAR. 4 - 1923 Filed 191

ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 3/1 (Month) - 3 (Day) - 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/28 ....., 1923, to, 3/1 ....., 1923, that I saw h[illegible] alive on 3/1 ....., 1923, and that death occurred, on the date stated above, at 6:00 m.

The CAUSE OF DEATH* was as follows:

Embolic Apoplexy

..... (Duration) ..... yrs ..... ds.

Contributory (SECONDARY) Chronic Nephritis

..... (Duration) ..... yrs ..... mos ..... ds.

(Signed) Henry T Casey M.D.

3-7 ....., 1923 [Address] Catonsville Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hough Chapple	3-5-, 1923
20-UNDERTAKER Daniel Fenton	ADDRESS 911 Pa Ave

NOTE. AGE should be stated EXACTLY. PHYSICIANS should TION is very important. See instructions on back of certificate. it may be properly classified. Exact statement of OCCUPA-

D73332

D73332

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 N. Calvert ST. 17 WARD)

2-FULL NAME Elizabeth A. Wagner

(a) RESIDENCE. NO. 1717 N. Calvert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wh	Widowed

5a If married, widowed, or divorced (or) WIFE of Jno. Wagner

6 DATE OF BIRTH (month, day, and year) Mar. 19 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jas. L. Yates

11 BIRTHPLACE OF FATHER (city or town) Canton
(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Eleanor Bran

13 BIRTHPLACE OF MOTHER (city or town) Ft. Wayne
(State or country) Ind.

14 Informant Dr. F. E. Wagner
(Address) 1006 Edmondson Avenue

15 MAR 4 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 20, 1923, to Mar 2, 1923

that I last saw her alive on Mar 2, 1923

and that death occurred, on the date stated above, at 12.55 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical History

(Signed) Frank E. Wagner M. D.

Mar 2, 1923 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	3/5 19 23
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73333

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Linden Avenue ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Benezet Gade

(a) RESIDENCE NO. 2011 Linden Avenue ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	64	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Gade

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann M. Benezet

13 BIRTHPLACE OF MOTHER (city or town) Phila.
(State or country) Pa.

14 Informant Miss Annette M. Gade Burial Permit Clerk.
(Address) 2011 Linden Avenue

15 Filed MAR 4-1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1923

17

I HEREBY CERTIFY, That I attended deceased from Feby 1st, 1923, to March 3rd, 1923, that I last saw h[illegible] alive on March 3rd, 1923 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 1 3 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) — yrs. — mos. 3 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Eugene Douglass M. D.

Mch 22 1923 (Address) 830 W. Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	3/5 1923
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son 805	N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

J73334

90 D73334

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3415 Duvall Ave. ST. 15 WARD)

2-FULL NAME Henry M. C. Bond

(a) RESIDENCE No. 3415 Duvall Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Feb. 17, '56.

7 AGE — Years: 67 — Months: — — Days: 13 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: York. Custom House.

9 BIRTHPLACE (city or town) (State or country): Calvert County, Md.

PARENTS

10 NAME OF FATHER: James A. Bond.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co., Md.

12 MAIDEN NAME OF MOTHER: Sarah E. Hance.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co., Md.

14 Informant: Dr. F. H. Degges

(Address) 3415 Duvall Ave

15 Filed MAR 5 - 1923 ROBERT M. KINSTLER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-2- 1923.

17 I HEREBY CERTIFY, That I attended deceased from 2-7-, 1923, to 3-2-, 1923

that I last saw him alive on 3-2-, 1923

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis, Edema Pulmonum Dactorus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Meredith Loyall M. D.

, 19 (Address) 3705 Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prince Frederick Calvert Md

DATE OF BURIAL: Mch 5 1923

20 UNDERTAKER: John O. Mitchell

ADDRESS: 2011 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

73335 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73335

CERTIFICATE OF DEATH.

101-001 D73335

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3108 Frederick Ave ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Tuttle

(a) RESIDENCE NO. 3108 Frederick Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Honora Tuttle

6 DATE OF BIRTH (month, day, and year) Aug. 26 1847

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. 0 13

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Tuttle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Pender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Eliz. Dolan

(Address) 3108 Frederick Ave.

15 MAR 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feby 28, 1923, to March 2, 1923, that I last saw him alive on March 1, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. mos 3 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. A. O'Neill, M. D.

3/2, 1923 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL 3/5 1923

20 UNDERTAKER Margaret G. Flynn ADDRESS 1547 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73336

CERTIFICATE OF DEATH. 101-001

D73336
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 N. Payson ST. 13 WARD)

2-FULL NAME Albert R. Wallace

(a) RESIDENCE NO. 1814 N. Payson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud E. Wallace

6 DATE OF BIRTH (month, day, and year) Aug. 2, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watch Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 39

(c) Name of employer Bell.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Wallace

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Maud E. Wallace
(Address) 1814 N. Payson St.

15 Filed 19 MAR 5 - 1923

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24th, 1923, to March 3d, 1923, that I last saw him alive on March 3d, 1923, and that death occurred, on the date stated above, at 8-15 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. B. Cramer, M. D.

19 (Address) 919 E. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Dear — DATE OF BURIAL Mar. 5 1923

20 UNDERTAKER Wm. J. Richter — ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D73337

REGISTERED NO. D73337

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Stonington Ave ST., Howard 26 WARD)

2-FULL NAME Caroline Rogers

(a) RESIDENCE NO. Stonington Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James S. Rogers

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm F. Rogers
(Address) Stonington Ave

15 MAR 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 27, 1923, to Mch 2, 1923, that I last saw her alive on Mch 1, 1923, and that death occurred, on the date stated above, at 1, P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis - Chronic.
Myocarditis - Arterio
Sclerosis.

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? None -

(Signed) Chas. W. Garnett, M. D.

Mch 3 1923 (Address) 132 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 5 1923
20 UNDERTAKER Wm J Tickner & Sons	ADDRESS North St

Spec.—1-10-21—M&T—1500 Bks.

John T. DeGaw

D73338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73338

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4016 Brookline ST., 15 WARD)

2-FULL NAME John T DeGaw

(a) RESIDENCE No. 4016 Brookline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	87	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Potter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John T DeGaw

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant P. E. Y. Jones

(Address) 4016 Brookline

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/16, 1923, to 3/2, 1923, that I last saw him alive on 3/2, 1923, and that death occurred, on the date stated above, at 6.00 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis (Interstitial)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dawsonville

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) Henry Russell, M. D.

3/3, 1923 (Address) 3902 Groveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 5 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

Spec.—8-24-14—M. & T.—2000 Bks.

D73339 HEALTH DEPARTMENT—CITY OF BALTIMORE D73339

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital St.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Watson

(Residence in Baltimore: No. Southern Hospital St.; fifty yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March (Month) 3 (Day) 1853 (Year)

7-AGE, 69 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Hat Maker
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Watson

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Margaret Helen

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Henry F. Lueck

(Address)..... 3536 Greenmount Ave

15-

Filed....., 191.....

MAR 5 - 1923 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 15 1923, to March 4 1923 that I saw him alive on March 4 1923 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

(Duration)..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(terminal) (Duration)..... yrs. ..... mos. 3 ds.

(Signed) Dudley P. Bowen M.D.

Nov. 4, 1923 (Address) 904 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. 3 mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 3536 Greenmount Ave

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Nov. 6..., 1923

20-UNDERTAKER Wm Cook

ADDRESS 502 E Balto

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73340

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Homewood Hosp

CITY OF BALTIMORE, (No. 2724 N Charles ST. 12 WARD)

2-FULL NAME Mary A. Whitaker

(a) RESIDENCE NO. 2107 Oak Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Henry Whitaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co.

12 MAIDEN NAME OF MOTHER Martha E. Duncan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant (Address) Joseph D. Whitaker 1816 Harlem Ave

15 Filed MAR 5 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 4 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11 1923, to Mar 4 1923, that I last saw h alive on Mar 4 1923, and that death occurred, on the date stated above, at 7 38 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 427 St Paul

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Urinary Findings

(Signed) Lee 2 Feldhoff, M. D.

3/4 1923 (Address) 2724 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Iowa — DATE OF BURIAL 3/7 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73341 HEALTH DEPARTMENT—CITY OF BALTIMORE D73341

38

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel J. Lynch

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Lynch

6 DATE OF BIRTH (month, day, and year) July 8-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner -

(b) General nature of industry, business, or establishment in which employed (or employer) Sailing -

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country) New York

PARENTS

10 NAME OF FATHER Dennis Lynch

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Dillon

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Ireland

14 Informant Records Mt Hope Retreat
(Address) Mt Hope Md

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22nd, 1921, to March 4, 1923, that I last saw h[illegible] alive on March 4, 1923, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Paresis -

(duration) 1 yrs. 8 mos. 0 ds.

CONTRIBUTORY (Secondary) Paretic mania - 2nd

(duration) 1 yrs. 8 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvary Cemetery New York

DATE OF BURIAL 3/7 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Hoff

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form —1-10-21—M&T—1500 Blks.

D 73342. HEALTH DEPARTMENT—CITY OF BALTIMORE D 73342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lanbach

1a RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73343

CERTIFICATE OF DEATH.

9 6

D73343

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 Orleans ST., WARD)

2-FULL NAME Juanita Dirkins

(a) RESIDENCE NO. 1639 Orleans ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) md

PARENTS

10 NAME OF FATHER Richard Dirkins

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) D. C

12 MAIDEN NAME OF MOTHER Ada Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Ada Kelly
(Address) 1639 Orleans St

15 MAR 5 - 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1923 to March 3, 1923, that I last saw h[illegible] alive on March 3, 1923, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Krieson M. D.

3/4 1923 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bury cemetery — DATE OF BURIAL: march 5 1923

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73344

CERTIFICATE OF DEATH.

178 ✓ D73344

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 E. Madison ST., 7 WARD)

2-FULL NAME John Thomas Brown

(a) RESIDENCE NO. 1708 E. Madison ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	calor	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ..... deceased

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE 46 Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... laBar

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Jacf Braun

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER mary Jahson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant annie Barnes

(Address) 1708 E madison st

15 MAR. 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 2 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 2 - 12 - , 1923, to 3 - 2 - , 1923,

that I last saw him alive on 3 - 1 - , 1923,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

1 day

(duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W H Haggett, M. D.

3-3- 1923 (Address) 611 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bury cemetery	march 5 1923
20 UNDERTAKER Edward Bryon	ADDRESS 631 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Margaret Johns

D73345

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D73345

CERTIFICATE OF DEATH

Hamilton

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Rosalie & Collins ave ST., 7 WARD)

2-FULL NAME Margaret Johns.

(a) RESIDENCE No. Rosalie & Collins ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert. E. L. Johns.

6 DATE OF BIRTH (month, day, and year) Dec 20 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) North Adams. Mass.

PARENTS

10 NAME OF FATHER Thomas A Beers

11 BIRTHPLACE OF FATHER (city or town) North (State or country) Mass.

12 MAIDEN NAME OF MOTHER Mary O Brien

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Robert. E. L. Johns. (Address) Rosalie & Collins ave

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923 to Mch 1st, 1923, that I last saw her alive on Mch 1st, 1923, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert. S. Kirk, M. D.

3/3/23 19 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery.	March 5 1923
20 UNDERTAKER	ADDRESS
George F. Ruth	1735 Harford ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73346

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Little Isles of the Por. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margeret Smith.

(a) RESIDENCE. No. Preston & Valley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Smith.

6 DATE OF BIRTH (month, day, and year) — 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Patrick Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Anne —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant Sister Florence, (Address) Preston & Valley

15 Filed MAR 5 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from No Record, 19 , to , 19 , that I last saw her alive on May 25, 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

, 1923 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 5 1923

20 UNDERTAKER H. C. Windsfeld ADDRESS 914 Green ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73347

CERTIFICATE OF DEATH.

74-501 D73347

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor Ward 10 WARD)

2-FULL NAME. Ellen Egan.

(a) RESIDENCE. NO. Preston & Caroline. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 22 Nov. 1842.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Egan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Catherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence, (Address) Little Sisters of the Poor

15 Filed MAR 5 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from No record, 19, to, 19,
that I last saw h Er alive on March 3, 1923,
and that death occurred, on the date stated above, at 7.10 P. m.
The CAUSE OF DEATH* was as follows:

Apoplectic convulsions

a few hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

March 4, 1923 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 5 1923

20 UNDERTAKER ADDRESS

J. C. Wiedefeld 914 Drummond Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73348

16, 1923 Mch

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

125 D73348

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Arthur Meady

(a) RESIDENCE No. 1803 W. Baltimore ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Meady

6 DATE OF BIRTH (month, day, and year) Nov 24-1885

7 AGE	Years	Months	Days	if LESS than 1 day, ...hrs. or ....min.
	37	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Standard Oil Co

9 BIRTHPLACE (city or town) ? (State or country)

PARENTS

10 NAME OF FATHER W. Meady

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Harris

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. By ..... Deputy.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 - , 1923, to March 4, 1923, that I last saw h.. alive on March 4, 1923, and that death occurred, on the date stated above, at 7 34 a m.

The CAUSE OF DEATH* was as follows:

Splenomegaly = general glandular enlargement

(duration) ..... yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Fluid in left chest

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Chas. R Bugg M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville Md	Mar 6. 23
20 UNDERTAKER C. Wm Wickersham & Sons	ADDRESS North Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- be properly classified. PHYSICIANS should state in plain terms, so that it may

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73349

CERTIFICATE OF DEATH.

100-001

D73349

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 Mosher ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Burton

(a) RESIDENCE. NO. 632 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 21-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Clyde Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Dora Pinder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Dora Burton
(Address) 632 Mosher St

15 Filed MAR 5 - 1923 . 19

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1923, to Mar. 2, 1923, that I last saw her alive on Mar. 2, 1923, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physicial Exam.

(Signed) Thos. L. McCandlish, M. D.

3-3-1923 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion. Cem.	Mch 5 1923
20 UNDERTAKER	ADDRESS
Samuel H. Chase & Son	1400 Mosher St

TION is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73350

CERTIFICATE OF DEATH.

D73350

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 259 Patapsco St - Westport 25 WARD)

2-FULL NAME William Ellsworth Cavey

(a) RESIDENCE. No. 259 Patapsco St St. Westport WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 26 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Thomas Cavey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Myrtle Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs Myrtle Parker Cavey (Mother) 259 Patapsco St Westport

15 MAR 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3rd March 1923

17 I HEREBY CERTIFY, That I attended deceased from 2nd March, 1923, to 3rd March, 1923, that I last saw him alive on 3rd March, 1923, and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Caldwell Woodruff M. D.

3/6 1923 (Address) Caldwell Woodruff, M. D. 1715 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ella Cemetery Ellicott City	Mar 6 1923
20 UNDERTAKER	ADDRESS
Nelson E. Viles	820 Mt Ave Westport

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Measles

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73351

CERTIFICATE OF DEATH.

57 D73351

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 6 WARD)

2-FULL NAME Philip Goob

(a) RESIDENCE NO. 225 N. Maderia St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mo. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or.... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred Goob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records.

(Address)

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17

I HEREBY CERTIFY, That I attended deceased from February 27, 1923, to March 2, 1923, that I last saw him alive on March 1, 1923, and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde Fisher, M. D.

3-8-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	Mar 5 1923
20 UNDERTAKER	ADDRESS
N. Sander's Sons	1710 Eutaw St.

TION is very important. See instructions on back of certificates.

...DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D73352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73352

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 N. Collington ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph O. R. Beach

(a) RESIDENCE NO. 1040 N. Collington ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11-09

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Artie O. Beach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary A. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Artie O. Beach

(Address) 1040 N. Collington ave

15 Filed 19

MAR 5 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1 1923

17

I HEREBY CERTIFY, That I attended deceased from February 6, 1923, to March 1, 1923,

that I last saw him alive on March 1, 1923,

and that death occurred, on the date stated above, at 4-20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia &
Valvular Heart Disease

(duration) yrs. mos. 25 da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory Test

(Signed) Albert Bingwald, M. D.

3/2/ 19 23 (Address) 162 E Hunt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL 3/5 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D73353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D73353

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 826 Born ally St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Hall

(Residence in Baltimore: No. 826 Born ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colo

5-Single, Married, Widowed or Divorced, (Write the word.): Mrs

6-DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7-AGE: 31 Yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 70

9-BIRTHPLACE, (State or Country): Balto Cty

PARENTS:

10-NAME OF FATHER: San Lewis

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Jones

13-BIRTHPLACE OF MOTHER, (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Husband

(Address) 826 Born ally

15-MAR 5 - 1923 Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March ~~Feb~~ (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.)

thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Don't know mos. ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. mos. ds.

(Signed) W K Grumbly M. D. (Coroner.)

3-5 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Md.

DATE OF BURIAL: 3-5 1923

20-UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

IT IS VERY IMPORTANT. See instructions on back of certificate. Returns may be properly classified. Exact statement of OCCUPATIONS should

Spec.—1-10-21—M&T—1500 Blks.

D73354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 23 v D73354

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp: ST., 24 WARD)

2-FULL NAME Bertha Berg

(a) RESIDENCE NO. Woodlawn Md: ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

(If non-resident give city or town and State)

TION is very important. See instructions on back of certificates.

may be properly classified. Exact statement of OCCUPA-

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17/1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Berg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dollie Kerzner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed MAR 5 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1923, to March 4, 1923, that I last saw her alive on March 4, 1923, and that death occurred, on the date stated above, at 9:50 9 m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Grippe ?

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. O'Connor, M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 3/5 1923

20 UNDERTAKER Jack Lewis 1439 E Balto

ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D73355 — 129 — D73355

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 8. S. Belair Road St.; 8 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah Frances Meyers

(Residence in Baltimore: No. 8. S. Belair Road St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July (Month) 9 (Day), 1854 (Year)

7 AGE: 58 yrs. 7 mos. 24 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Nicholas Evans

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha Clark

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Meyers

(Address) 8 S. Belair Road

15. Filed MAR 5 - 1923 — ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 3 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1919, to Mch 3rd, 1923, that I saw her alive on March 2nd, 1923, and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank A. Glantz M. D.

Mch 5, 1923 (Address) 3244 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Ebenezer Cemetery — DATE OF BURIAL: March 6, 1923

20 UNDERTAKER: Fred'k Loesch & Sons — ADDRESS: Fullerton Md

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. — Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should

Spec.—1-16-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73356

CERTIFICATE OF DEATH. X 11-001

D73356

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2230 E. NORTH AVE. ST., 9 WARD)

2-FULL NAME MARY KUPISCH

(a) RESIDENCE NO. MONKTON MD. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: FEMALE

4 COLOR OR RACE: WHITE

5 Single, Married, Widowed, or Divorced, (write the word): SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) MAY 28. 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): AT HOME

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): BALTO. CO. MARYLAND

PARENTS

10 NAME OF FATHER: GOTTLIEB KUPISCH

11 BIRTHPLACE OF FATHER (city or town) (State or country): GERMANY

12 MAIDEN NAME OF MOTHER: CLARA COOK

13 BIRTHPLACE OF MOTHER (city or town) (State or country): BALTO. CO. MARYLAND

14 Informant: GOTTLIEB KUPISCH
(Address): MONKTON MD.

15 FILED MAR 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1923, to Mar 3, 1923, that I last saw h alive on Mar 3, 1923, and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? ----

Did an operation precede death? ---- Date of ----

Was there an autopsy? ----

What test confirmed diagnosis? Physical Signs

(Signed) E. E. Klauber, M. D.

Mar 4, 1923 (Address) 1307 N Pat Patrick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ST. JOSEPHS CEMETERY — DATE OF BURIAL: MARCH 6 1923

20 UNDERTAKER: Fred'k Lassahn & Sons — ADDRESS: FULLERTON. MD.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified. so that it ma- terms, in plain

Spec.—1 10-21—M&T—1500 Bks.

16 D73357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 ✓ D73357

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Tillman,

(a) RESIDENCE No. 1207 Brevard St. City. WARD Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred, yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND OF~~ ~~(or) WIFE OF~~ Anna Jackson, mother,

6 DATE OF BIRTH (month, day, and year) Sept. 15 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	23.	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sta. W. H.W.

(b) General nature of industry, business, or establishment in which employed (or employer): —"—

(c) Name of employer: —"— 037

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER Irvin Tillman.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Anna Read.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1922, to March 3, 1923,

that I last saw her alive on March 3, 1923,

and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis.

Tbc. bronchopneumonia (2 weeks).

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) operation for suppuration

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12-22-22

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Karl A. Meyer, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gloucester F. Wks. Gloucester Co. Va.

DATE OF BURIAL: 3/5 1923

20 UNDERTAKER: Cecil Hemsley

ADDRESS 778 N Eddelston

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified. PHYSICIANS should state in plain terms, so that

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73358

CERTIFICATE OF DEATH.

11-001

D73358

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Prestman St. 15 WARD)

2-FULL NAME Annie E. Barber

(a) RESIDENCE No. 1619 Prestman St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) June 20, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Maud Simmonds

(Address) 1619 Prestman St.

15 MAR. 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16th, 1923, to March 1, 1923, that I last saw h alive on March 1st, 1923, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Acute Coronary sclerosis Hypertension (Acute Brights Disease) with pulmonary edema

(duration) ? yrs. ? mos. 15 da.

CONTRIBUTORY (Secondary) General Cyanosis & collapse of ext (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ---

Was there an autopsy? no

What test confirmed diagnosis? physical Exam & urine

(Signed) Geo. C. Hall, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. M. E. Cemetery — DATE OF BURIAL 3/7 1923

20 UNDERTAKER James W. Dennis — ADDRESS, 313 Preston

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Gillian Johnson

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D73359

D73359

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Gillian Johnson ST., 19 WARD)

2-FULL NAME 1578 W-Lexington

(a) RESIDENCE No. 1578 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov-27-1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Sidney Johnson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Anna Easley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Anna Johnson
(Address) 1578 W. Lexington

15 MAR 5-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1923, to 3/4, 1923.

that I last saw her alive on 3/4/23, 19....;

and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 13 ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) W. J. Johnson, M. D.

19 (Address) 1618 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: March 6th 1923

20 UNDERTAKER: A. Jones

ADDRESS: 1114 S. Gilmor St

TION is very important. See instructions on back of certificates.

Spec.—1-10[illegible]—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73360

CERTIFICATE OF DEATH.

129 D73360

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Hollins St. ST., 19 WARD)

2-FULL NAME John Robert Steele

(a) RESIDENCE No. 1727 Hollins St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Steele

6 DATE OF BIRTH (Month, day and year) Aug 27th 1887

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or ..... mins.
	35	6	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Columbia Fertilizer Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert J. Steele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Higginson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George H. Steele (Address) 1727 Hollins St

15 MAR 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22nd, 1922, to March 3rd, 1923.

that I last saw h[illegible] alive on March 3rd, 1923

and that death occurred, on the date stated above, at 7.25 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Nephritis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Herrington M. D.

3/3/23 (Address) 701 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL March 6, 1923

20 UNDERTAKER C. W. Dill — ADDRESS 3109 Fredk. Ave.

TION is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA- PHYSICIANS should state in plain terms, so that

Spec. 1-10-21—M&T 1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73361

CERTIFICATE OF DEATH.

100-001

D73361

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hollis Ferry Road Lakeland 25 WARD)

2-FULL NAME Ruth Estell Forester

(a) RESIDENCE NO. Hollis Ferry Road Lakeland WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16-1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
2	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John A. Forester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Eva Dietzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant John A. Forester (Address) Hollis Ferry Road Lakeland

15 MAR 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Feby 24, 1923, to Mch 3, 1923,

that I last saw h[illegible] alive on Mch 3, 1923,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) same

(duration) ... yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. L. McKieffer, M. D.

Mch 5, 1923 (Address) 5320 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar. 6 1923
20 UNDERTAKER	ADDRESS
George L. Schwab	2101 Eutaw Pl.

THIS CERTIFICATE: PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Stsc—12-23-21—E.B.R.S.—400 Bks.

D73362

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D73362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 240 E. Montgomery St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Vogel

(a) Residence No. 240 E. Montgomery St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles Vogel

6-DATE OF BIRTH (month, day and year) July 28th - 1852

7-AGE. 70 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Geo. Strauss

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Gleiber

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11-

(Informant) Louise E. Morgan

(Address) 240 E. Montgomery St.

15-

FILED MAR 5 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 5 - 1923

17- I HEREBY CERTIFY, That I attended deceased from June 1908 to Mar 5 1923

that I last saw her alive on Mar 5 1923

and that death occurred, on the date stated above, at 12.25 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Ch. Interstitial Nephritis 10 yrs.

Obstructive Jaundice 5 wks.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Partial. Gall Stones.

What test confirmed diagnosis?

(Signed) Geo A Strauss M. D.

3/5 1923 (Address) 1800 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Mar 7 1923

20-UNDERTAKER. F. A. Krause & Son — ADDRESS 703 Hanover

Instructions on back of certificates. Statistics are confidential. Exact statement of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Bks.

D73363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73363 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1719 S. Charles St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Wilburn

(a) Residence No. 1719 S. Charles St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 12 1903

7-AGE, 19 yrs. 11 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Alvin C. Wilburn

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Annie Guesman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Alvin C. Wilburn

(Address) 1719 S. Charles

15- Filed MAR 5 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 2, 1923.

17- I HEREBY CERTIFY, That I attended deceased from Feb'y 20, 1923 to March 2, 1923.

that I last saw her alive on March 2 1923.

and that death occurred, on the date stated above, at 1 0 P. m.

The CAUSE OF DEATH* was as follows:

Acute parenchymatous nephritis

(Duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Chem. of Urinary

(Signed) A. W. Magruder M. D.

3.3. 1923 (Address) 12 E. Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Cemetery — DATE OF BURIAL. Mar 6 1923

20-UNDERTAKER. F. C. Cramerton — ADDRESS 903 Hanover

Instructions on back of certificates. Exact statement of OCCUPATION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No other abnormal Condition

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73364

CERTIFICATE OF DEATH.

148 D73364

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Harlem av St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Genevieve Alice Chambers

(Residence in Baltimore: No. 1617 Harlem av St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 14 (Day), 1895 (Year)

7-AGE, 27 yrs. 7 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... D.

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER. Edwd J Farrigan

11-BIRTHPLACE OF FATHER (State or Country). Balto Co. Md

12-MAIDEN NAME OF MOTHER Catherine E Tolan

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant)..William G Chambers

(Address)..1617 Harlem Ave

15-MAR 5 - 1923 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 3 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to March 3 1923, that I saw h[er] alive on March 3 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Partum Hemorrhage

Immature Separation of Placenta

..... (Duration) Hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

..... (Duration) ....yrs. 2 mos. ds.

(Signed) Marshall G. Smith M. D.

March 3, 1923. (Address) 1821 Calhoun St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Mar. 6, 1923

20-UNDERTAKER John F Denny — ADDRESS 715 Light St

Fold here. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73365

D73365

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Kohlhafer

(a) RESIDENCE NO. 505 W Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of ~~(or)~~ WIFE of Geo. Henry Kohlhafer

6 DATE OF BIRTH (month, day, and year) May 10 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Bayline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs H. B. Jefferson

(Address) 505 W Hamburg st

15 MAR 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3- 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-2-, 1923, to 3-3-, 1923, that I last saw h.w alive on 3-3-, 1923, and that death occurred, on the date stated above, at 1 52 p m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Heart

(duration) yrs. mos. 3 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-3-23

Removal of gall bladder

Was there an autopsy?

What test confirmed diagnosis? Op. findings

(Signed) Newton D. Carr, M. D.

3/3/, 1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Mar 7 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73366

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

D73366

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 710 WARD)

2-FULL NAME William Carnes

(a) RESIDENCE NO. 2810 Frederick ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 14 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md

PARENTS

10 NAME OF FATHER Wm. E. Carnes

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Margaret Fosta 3/5/23

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Mrs Margaret Carnes
(Address) 2810 Frederick Ave

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17 I HEREBY CERTIFY, That I attended deceased from march 1, 1923, to March 4, 1923, that I last saw him alive on March 4, 1923, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria nasal, tonsilar, pharyngeal & laryngeal

(duration) - yrs. - mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 4+ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures (+)

(Signed) R MacLawan M. D.

(Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 3/6 1923

20 UNDERTAKER E. W. Caplan — ADDRESS 924 E Lexington

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73367

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 W. Mulberry ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles William Buck

(a) RESIDENCE. No. 1310 W. Mulberry ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (~~WIFE~~) of: Mary E. Buck

6 DATE OF BIRTH (month, day, and year): Mar. 1860

7 AGE: Years 62 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry M. Buck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna M Lindemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Frederick H. Buck

(Address) 1307 Rutland Ave

15 FILED MAR 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 26th 1923 to March 5th 1923 that I last saw h~~im~~ alive on March 5th 1923 and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 2 yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J. W. Clinton Clift, M. D.

3/5 1923 (Address) 1312 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul's Violetville Md

DATE OF BURIAL: 3/7/23

20 UNDERTAKER: Jos. Weber & Son

ADDRESS: 250 E Lanvale

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION should state properly classified. If it may be

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73368

CERTIFICATE OF DEATH.

Town 11 129 D73368

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 N. Fulton Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Weber.

(Residence in Baltimore: No. 646 Fulton Ave North St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, Febry (Month) 14 (Day), 1839 (Year)

7-AGE, 84 yrs. — mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired Grocer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany In U.S. 60 yrs.

PARENTS.

10-NAME OF FATHER, ... Weber

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George E. Shannon

(Address) 700 Fulton Ave

15- Filed MAR 5 - 1923, 191..... ROBERT R. KRAUTER, Clerk.
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 3. (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1922, to Mch 3 1923; that I saw him alive on Mch 20 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic

(Duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Pericarditis

(Duration) ✓ yrs. 6 mos. ✓ ds.

(Signed) George E. Shannon M. D.

Mch 3, 1923 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, 3/6/23 191...

20-UNDERTAKER, Geo. J. Hurt & Son — ADDRESS 3 E. Lanvale

Over

Please write plainly. Use pen and ink. Punctuate. Spell out words. Do not abbreviate. Answer questions on back of certificate. Exact statement of OCCUPATION is very important. If you do not know the exact information required about any item, state that fact.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

97369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Lakeland ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME .....

(a) RESIDENCE No. .....ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14

Informant .....
(Address)

15

Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

TION is very important. See instructions on back of certificates. ... it may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73370 D73370

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 612 N. Chapel ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meridel Brooks

(Residence in Baltimore: No. 612 N. Chapel St.: Life year mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	Married

6-DATE OF BIRTH, August 6, 1891
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
31 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: General Housework
(b) General nature of industry, business, or establishment in which employed (or employer): D70

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Tom. Robinson

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Lidie Hurst

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elliott (undertaker)

(Address) 1225 Ashland Ave

15- Filed MAR 5 - 1923 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2nd, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1923, to March 2nd 1923, that I saw her alive on March 1st 1923, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R J Young M. D.

3/2, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery	March 6 1923
20-UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1225 Ashland Ave

Use instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Blks.

1618 29
D73371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D73371

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 5 WARD)

2-FULL NAME Courtney Dorman

(a) RESIDENCE No. 407 Wayson St. City ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Rodgers

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) .....

12 MAIDEN NAME OF MOTHER Mary Dorman

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1923 to March 3, 1923 that I last saw her alive on March 3, 1923 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) X

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) A A Mead M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 6, 1923
20 UNDERTAKER Wm Robert A Elliott	ADDRESS 1725 Baltimore Apt

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified. PHYSICIANS should state

Spec. 1-10-21 M&T 1500 Blks.

D73372

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D73372

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas

(a) RESIDENCE No. 402 Ogston St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single ----

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
35	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labdrer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Monroe Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Municipal Hospital Records.

(Address)

15 FILED MAR 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 28, 19 23, to March 2, 19 23.

that I last saw him alive on March 2, 19 23,

and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis ?

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McCa, M. D.

3-3-, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	March 6th 23
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

IMPORTANT.—PHYSICIANS should state may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73373

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Thomas Salter

(a) RESIDENCE. NO. 10 E. Mulberry St. ST., WARD.

(Usual place of abode) more than

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) May 8, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Casket Co.

(c) Name of employer National Casket Co.

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 MAR 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 21 1923, to March 2, 1923, that I last saw h.. alive on March 2, 1923, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) Feb. 21 - Mar 2nd yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At 10 E Mulberry

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis?

(Signed) H. B. Gosnell, M. D.

3-4 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 5, 1923
20 UNDERTAKER Harry W. Witzke	ADDRESS 1521 W Lombard.

TION is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73374

CERTIFICATE OF DEATH.

10

D73374

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 S. Mount St. St. 19 Ward)

2-FULL NAME Gladys May Dembinsky

(a) RESIDENCE. No. 323 S. Monut St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. II mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): March 14, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	II	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: William Dembinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Florence M. Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant (Address): William Dembinsky, 323 S. Mount St.

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 3. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1923, to March 3, 1923, that I last saw h.. alive on March 3, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis (Diphtheria)

Acute Embolism

(duration) ....yrs. ....mos. 15+ ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edward V. Cowdrey, M. D.

3/4/23 (Address) 24 N Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 6, 1922

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 W. Lombard St

Important. See instructions on back of certificates. Exact statement of OCCUPA- ... State

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73375

CERTIFICATE OF DEATH.

66 D73375

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 113 So. Albemarle ST.; 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. Clowman
(Residence in Baltimore: No. Living House Front + Fayette St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Unknown

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, about 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Umbrella Mender
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Police Dept.
(Address) Eastern Dist

15-
Filed MAR 5 - 1923 191.....
ROBERT R. KRAUTER, Registrar.
Burial Permit Granted.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 25 ....., 192.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest / Inquiry (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said Inquest and (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Mch 23 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL
DATE OF BURIAL, ..., 19....

20-UNDERTAKER
ADDRESS MAR 5 - 1923

Commissioner of Health.

OUTSIDE MORGUE

IMPORTANT: PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very ... See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73375 **CERTIFICATE OF DEATH.** 170 D73376

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 924 Watson St. 3 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kinet

(Residence in Baltimore: No. 924 Watson St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Unknown

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 65 About yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country) Unknown
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Police Dept
(Address) Eastern Dist

15- Filed MAR 5 1923 19.. Registrar. ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 26, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, au (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage Brain

Suicide Shot self in Right Temple

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Thos. P. Horton M. D. (Coroner.)

March 3rd 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 19..

20-UNDERTAKER, ADDRESS

Commissioner Health, MAR 5 - 1923

Per Wm. E. WOODALL

JOHNS HOPKINS HOSPITAL

THE MORGUE

Penalty. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. Exact statement of OCCUPATION is very

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73377

161-001 D73377

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 19 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Hill

(a) RESIDENCE NO. (Usual place of abode) University Hospital ST. 703 S Caliburn St WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Sin

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 27-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
				30 minutes

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) University Hospital Baltimore

PARENTS

10 NAME OF FATHER Howard W. Hill

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. [illegible]

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant (Address) University Hospital. JOHNS HOPKINS HOSPITAL

15 Filed MAR 5 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to Feb. 27, 1923, that I last saw her alive on Feb. 27, 1923, and that death occurred, on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health;

ADDRESS MAR 5 - 1923

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Fold state

Spec.—1-10-21—M&T—1500 Blks.

161901.
(")

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73378

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. D73378

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. " " " ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Duvall.

(a) RESIDENCE NO. 2316 Foster Ave City ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred "Life" yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Esther Duvall (mother),

6 DATE OF BIRTH (month, day, and year) Feb. 25 1923.

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry, business, or establishment in which employed (or employer): Son
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Esther ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records.

15 Filed MAR 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1923, to Feb. 26, 1923, that I last saw him alive on Feb. 26, 1923, and that death occurred, on the date stated above, at 10½ A. m.

The CAUSE OF DEATH* was as follows:

Prematurity
Life
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mare
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Wood, M. D.
, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

MAR 5 - 1923

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

Edward C Hughes

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73379

CERTIFICATE OF DEATH.

101-101 D73379

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. E. 212 E. 24 St. St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward C Hughes

(Residence in Baltimore: No. 212 E. 24 St. St. 69 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sep (Month) 26 (Day), 1853 (Year)

7-AGE.	If LESS than 1 day,
44 yrs. mos. da.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steward
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel Emerson

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, James Haughes

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Margt Clarke

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Filed name Haughes

(Address 212 E 24th St

15- MAR 5 - 1923, 191...

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 23 1923, to Mch 2 1923, that I saw him alive on Mch 2 1923, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration).....yrs.....mos.....da.

CONTRIBUTORY..... (Secondary)

..... (Duration).....yrs.....mos.....da.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral	March 6, 1923
20-UNDERTAKER E A Wedefeld Jr	ADDRESS 501 E 22 St

Fill out all items. Insert "None" where necessary. Information required on back of certificate. Carefully examine statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 1921 N Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G Plitt

(a) Residence No. 1921 N Lanvale St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace Plitt

6-DATE OF BIRTH (month, day and year): Feb 4-1877

7-AGE: 46 yrs. mos. 2 ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): Bkry

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: W H Plitt

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary C Kahlert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

11-Informant: G Irvin Plitt

(Address): 1921 N Lanvale St

15-Filed 5-1923 Robt. P. HARRISON Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 2-1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 8 1923 to Mar 2 1923

that I last saw him alive on Mar 1 1923

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chr. interstit nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema of lungs

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Warren A. Todd M. D

3/3, 1923 (Address) 735 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cemetery	March 5 1923
20-UNDERTAKER	ADDRESS
Wm C Miller	2334 Jeffers

If the Statement of OCCUPATION is very important — see Back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73381

CERTIFICATE OF DEATH.

91-002

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor 10 WARD)

2-FULL NAME Mary James.

(a) RESIDENCE No. Preston & Valley Sts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 20 June 1843

7 AGE: Years 77; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hartford Co, Md.

PARENTS

10 NAME OF FATHER Edward K. James

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Adeline Flowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence, (Address) Preston & Valley Sts

Filed Mch 5, 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19, to, 19, that I last saw her alive on March 3, 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Arteri sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Warner, M. D.

March 5, 1923 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dublin Md — DATE OF BURIAL: March 7 1923

20 UNDERTAKER: John O Mitchell — ADDRESS: 1201 W Fay

TION is very important. See instructions on back of certificates.

that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73382

CERTIFICATE OF DEATH.

35 D73382

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 26 WARD)

2-FULL NAME Valentine Hamer.

(a) RESIDENCE No. 1019 S. East, Wm. Cathy ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a (If married, widowed, or divorced) HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Sept. 7, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	5	25.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child. (+)
(b) General nature of industry, business, or establishment in which employed (or employer): (+)
(c) Name of employer: (+)

9 BIRTHPLACE (city or town) (State or country): Maryland. (+)

PARENTS

10 NAME OF FATHER: Michael Hamer. (+)

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md (+)

12 MAIDEN NAME OF MOTHER: Anna Koss. (+)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md (+)

14 Informant: JOHNS HOPKINS HOSPITAL
(Address) Robert P. Merriken.

3-15 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1923, to March 4, 1923, that I last saw him alive on March 4, 1923, and that death occurred, on the date stated above, at 12:45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis knee, left, with secondary infection

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home. Baltimore Md

Did an operation precede death? Yes Date of Feb 10, 21, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Sign & Symptoms

(Signed) Geo. W. Leadbetter M. D.

3/4, 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: March 6, 1923

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS 1,39 Eager

TION is very important. See instructions on back of certificates. ... that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73383 ✓ D73383

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2910 Dillon ST., 1 WARD)

2-FULL NAME Sarah Jane Webb

(a) RESIDENCE NO. 2910 Dillon ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thos. H. Webb

6 DATE OF BIRTH (month, day, and year) June 4-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Easton
(State or country) Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known

14 Informant Sarah E. Ayres
(Address) 2910 Dillon St

15 Filed ...., 1923 Robert F. Harrison, Registrar
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 4, 1923, that I last saw h[illegible] alive on March 4, 1923 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) O. H. B. Titlow, M. D.

3/5, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Mch 7 1923

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1739 E. Eager St

IMPORTANT. It may be properly classified. Exact statement of OCCUPATION should state very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73384

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73384

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH 5214

CITY OF BALTIMORE: (No. 5214 Milton Ave St., 27 WARD)

2-FULL NAME Barnet Hahn

(a) RESIDENCE NO. 5214 Milton Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PHYSICIANS should state name, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wht	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 4/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Boy

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Barnet Hahn

11 BIRTHPLACE OF FATHER (city or town) Russ
(State or country)

12 MAIDEN NAME Bertha Nicie Heer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs A. Hahn
(Address) 5214 Milton Ave

15 Filed 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 4, 1923 to Mch 4/23, 1923.

that I last saw h alive on Mch 4, 1923

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Dyspepsia, malformation & Strangulation due to cord around neck

one hour (duration)

CONTRIBUTORY (Secondary) Cyanosis one hour (duration)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) [illegible] M. D.

3/4, 1923 (Address) 1605 N Monta Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL Mch 5 1923

20 UNDERTAKER Wm Buckner Sons — ADDRESS Norfolk

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73385

CERTIFICATE OF DEATH.

101-001

D73385

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Woodbourne Ave ST.; 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert Leslie Ensor

(Residence in Baltimore: No. 500 Woodbourne Ave St.; ....yrs., 10 mos. ....ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 4 (Day), 1923 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 10 mos. ....ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto, Md.

PARENTS.

10-NAME OF FATHER, William L. Ensor

11-BIRTHPLACE OF FATHER (State or Country), Ashland, Balto Co., Md

12-MAIDEN NAME OF MOTHER Mary E. Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Fleisher, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Ensor

(Address) 500 Woodbourne Ave

15- Filed 1923 Robert F. Harrison, ..., 191.....
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1 1923, to March 4 1923, that I saw h/m alive on March 4 1923, and that death occurred, on the date stated above, at 11 A.M. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

..... (Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Tobacco

..... (Duration) ....yrs. 9 mos. 1 ds.

(Signed) D. W. Bishop M. D.

March 4, 1923 (Address) 501 S Bond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 10 mos. ds. In the State yrs. 10 mos. ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Glenwood Balto Co.	March 6, 1923.
20-UNDERTAKER	ADDRESS
Wm C Brooks	Sparks

Spec.—1-10-21—M&T—1500 Bks.

D73386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73386

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sisters of the Poor ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Hartman.

(a) RESIDENCE NO. Preston Valley Hts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1860

7 AGE: Years 62 | Months 10 | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Casper Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Ann Gerken

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence

(Address) Preston Valley Hts

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1 1923 to March 4 1923.

that I last saw h alive on March 3 1923,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy 4

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Wagner, M. D.

March 5 1923 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 6 1923
20 UNDERTAKER	**ADDRESS**
H. C. Wiedefeld	914 Greenmount Av

IMPORTANT: Physicians should be careful that every certificate may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73387

CERTIFICATE OF DEATH.

129 D73387

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklintown Rd ST.; 28 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael J Hennessie

(Residence in Baltimore: No. Franklin Rd Lane St.; 69 yrs., 0 mos. 4 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Nov. 27, 1853 (Month) (Day) (Year)

7-AGE, 69 yrs. 3 mos. 4 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Maryland " "

PARENTS.

10-NAME OF FATHER, John Hennessie

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Alice C Hennessie

(Address) Franklintown Md

15- Robert F. Harrison,

Filed....., 191.....

1923 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3rd, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4th 1923, to March 3, 1923, that I saw him alive on March 3rd 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) ... yrs. 2 mos. 1 da.

CONTRIBUTORY (Secondary) Brights Disease

(Duration) ... yrs. 1 mos. ... da.

(Signed) Geo J Everhart M. D.

March 4, 1923 (Address) Woodlawn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	March 6, 1923

20-UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73388

CERTIFICATE OF DEATH.

166 D73388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gerhold

(a) RESIDENCE NO. Bay View Hospital. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 Filed ..... 19 ..... Robert F. Garrison, Registrar

3-1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1921, to March 2, 1923, that I last saw him alive on March 2, 1923, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Toxic nephritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bichloid of mercury poisoning (duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Clyde McNeil, M. D.

3-3-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthews	Mch 6 1923
20 UNDERTAKER Burkler & Burkler	ADDRESS 1739 Eager

Dur

Should state Exact statement of OCCUPA-

should be properly classified. See instructions on back of certificates.

D73389

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D73389

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 N. Carrollton Av. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles R. Bunger,

(Residence in Baltimore: No. 527 N. Carrollton Av. St., 76 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	married.

6-DATE OF BIRTH July 20, 1836
(Month) (Day) (Year)

7-AGE 86 yrs. 8 mos. — ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore, Md.

PARENTS

10-NAME OF FATHER Wm. Bunger

11-BIRTHPLACE OF FATHER (State or country) Howard Co, Md.

12-MAIDEN NAME OF MOTHER Eliz. Ricketts

13-BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Bunger

(Address) 527 N. Carrollton Av.

15- Robert F. Harrison,
1923 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH March 4th, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1923, to, March 4th 1923, that I saw him alive on March 3rd 1923, and that death occurred, on the date stated above, at 12.30a. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

unknown (Duration) — yrs. — mos. — ds.

Contributory (SECONDARY) .....
(Duration) ..... yrs ..... mos. ..... ds.

(Signed), Charles G. Ritter, M. D.
March 4th, 1923 [Address] 1101 W. Lanvale St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Greenmount — DATE OF BURIAL March 6, 1923

20-UNDERTAKER George J. Smith — ADDRESS 1532 Hollins St

Very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. Physicians should

Spec.—1-10-21—M&T—1500 Blks.

D73390

HEALTH DEPARTMENT—CITY OF BALTIMORE

41 D73390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Norwood

(a) RESIDENCE NO. 3409 Carlisle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Ida Lee Norwood

6 DATE OF BIRTH (month, day, and year) April 21-1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
65	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres. Nolcek Piston Ring Co.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md -
(State or country)

PARENTS

10 NAME OF FATHER Wm Norwood -

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Ryan

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Wife, 3409 Carlisle Ave
(Address)

15 3-5-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4-1923

17

I HEREBY CERTIFY, That I attended deceased from 3-1-1923, to 3-4-1923,

that I last saw h[e] alive on 3-4-1923,

and that death occurred, on the date stated above, at 2 53 a.m.

The CAUSE OF DEATH* was as follows:—

Streptococcus viridans septicemia -

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Infected tooth (duration) yrs. mos. 6 ds.

18 Where was disease contracted, if not at place of death? Where tooth was extracted

Did an operation precede death? Yes Date of 3-2-23

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) A.B. Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION [illegible]	DATE OF BURIAL
Loudon Park	March 7 1923
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Should state if name may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73391

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Womens Home ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Welsh

(a) RESIDENCE No. Aged Womens' Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Sarah Merriken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ella Jones

(Address) 400 Pleasant

15 Dec. 1923 19

Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1922, to March 4, 1923, that I last saw h alive on March 4, 1923 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Hoonard, M. D.

March 5 19 23 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Mar 6 1923

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D73392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73392

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3217 Piedmont ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Restivo

(a) RESIDENCE NO. 3217 Piedmont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	White.

5a If married, widowed, or divorced
HUSBAND of
~~or WIFE of~~ Theresa Restivo

6 DATE OF BIRTH (month, day, and year) Feb. 1-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Marion Restivo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14

Informant Mrs A. DiPaoli

(Address) 3217 Piedmont

15 MAR 1923 .19.....

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3- 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 5th, 19 22 to Mch 3rd, 19 23.

that I last saw him alive on Mch 2nd, 19.....

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Microscop + Chem

What test confirmed diagnosis?

(Signed) August Hom, M. D.

.19 (Address) 405 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ken Cathedral	Mar. 7 1923

20 UNDERTAKER Wm Cook. ADDRESS 502 E Fairfield

Be sure that every certificate is properly classified. Exact statement of OCCUPATION may be very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Jane L. Hendricks)

D73393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73393

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 Druid Hill Ave ST. 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Louise Hendricks

(a) RESIDENCE No. 1539 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James E. Hendricks

6 DATE OF BIRTH (month, day, and year): June 28, 1848

7 AGE: Years 74 Months 7 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer): Duties

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas L. Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Susan Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Susie Kunz

(Address) 1839 E. Chase St.

15 1923 Robert E. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to Mar 3, 1923, that I last saw her alive on Mar 2, 1923, and that death occurred, on the date stated above, at 115 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M.D.

3/3, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. View Cem

DATE OF BURIAL: Mar. 6 1923

20 UNDERTAKER: Easton Sons

ADDRESS: Elkton Md

Burial Permit

IMPORTANT.—Every question must be answered if possible. Unknown or doubtful answers should state the fact. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Burrin H. Mallery)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73394

CERTIFICATE OF DEATH.

X 90

D73394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hosp. (ST.:) 9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Burrin H. Mallery.

(a) RESIDENCE. No. Binghamton N.Y. ST., WARD. Binghampton N.Y.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Laura E. Mallery

6 DATE OF BIRTH (month, day, and year) Dec 21, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
49				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Western Union

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Calvin Mallery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mallal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Wm. Mallery (Address) 744 Jackson Ave 2774

15 -1923 , 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17

I HEREBY CERTIFY, That I attended deceased from March 4 1923 to March 5 1923 that I last saw h. alive on March 5 1923 and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? N. Y.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) F. V. Szczerbicki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Binghamton, Broome Co NY	Mar 5/23 19
20 UNDERTAKER	ADDRESS
Wm Cook	507 E Monument

Form is very important. See instructions on back of certificates. Exact statement of OCCUPATION should be properly classified.

Manuel Lucy

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73395 1924

CaeHEALTH DEPARTMENT—CITY OF BALTIMORE

D73395

CERTIFICATE OF DEATH.

90 1854

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) 1926 Mc. Henry St. (or) WARD)

2-FULL NAME Elizabeth Albrecht

(a) RESIDENCE. NO. 1926 Mc. Henry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 26 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~Male~~ Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Albrecht

6 DATE OF BIRTH (month, day, and year) May 5 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Virginia Shelby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) W. F. Albrecht 1926 Mc. Henry St.

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923, to March 3, 1923, that I last saw her alive on March 3, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(duration) yrs. mos. 4½ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marshall G. Smith, M. D.

March 5 1923 (Address) 1182 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	3/6 1923

20 UNDERTAKER F B Kefauver ADDRESS 2256 Fremont Ave

PHYSICIANS should state properly classified. Exact statement of OCCUPA- very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73396

CERTIFICATE OF DEATH.

101-001

D73396

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 W. Franklin St. ST.: 17 WARD)

2-FULL NAME Eugene Glandell.

(a) RESIDENCE. NO. 806 W. Franklin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret S. Glandell

6 DATE OF BIRTH (month, day, and year) July 27, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John B. Glandell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) France.

12 MAIDEN NAME OF MOTHER Cornelia Coy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md.

14 Informant Margaret S. Glandell
(Address) 806 W. Franklin St.

15 1923 . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to Mch. 3, 1923, that I last saw him alive on Mch. 3, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms.

(Signed) Wm. M. Pannebaker, M. D.

3/5. 1923 (Address) 209 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Mch. 6 1923

20 UNDERTAKER Jos B Cook ADDRESS 1003 W Balto

Be sure that this is properly classified. Exact statement of Occupation should state whether Employer, Employee or Operative. See instructions on back of certificate.

D73397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73397

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Infirmary St. 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Elizabeth Portner

(Residence in Baltimore: No. 2431 W. North Ave. St. yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Feb. 12 (Month) (Day) 1880 (Year)

7-AGE.	If LESS than 1 day.
43 yrs. 0 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Portner

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Kate Vogt

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Portner

(Address) 2431 W. North Ave.

15-

Filed Mch 5 1923 1923 Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 4th (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisitory (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquisitory (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) 2 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. P. T. Hennessy M. D. (Coroner.)

Mch. 5th 1923 (Address) 2802 Edmondson Ave.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	Mch. 6th 1923
20-UNDERTAKER.	ADDRESS
J. B. Cook	1003 W. Balto.

Instructions on back of certificate. Exact statement of OCCUPATION should be given. Property certified.

D73398

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ D73398

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 20 E. Rodgers St. 29 WARD)

Registered No. C

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Kathrin W. Coe.

(Residence in Baltimore: No. 20 E. Rodgers ave St. 4 yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word): Single

6 DATE OF BIRTH: January 1" (Month), 1848 (Year)

7 AGE: 75 yrs. 2 mos. 3 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work: Florist

(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or Country): Cockeysville, Md.

PARENTS.

10 NAME OF FATHER: William B. Coe

11 BIRTHPLACE OF FATHER (State or Country): Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER: Eliza Badders

13 BIRTHPLACE OF MOTHER (State or Country): Baltimore Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Cyrus W. Coe (Informant)

Manhattan Ave. Mt. Washington Heights (Address)

15

1923 ....., 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 4 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Disease

Pleurisy X

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos J Morrissey M. D. (Coroner)

Mar 4, 1923 (Address) 3602 Pinkard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Mch. 6" 1923

20 UNDERTAKER: Jos B Cook

ADDRESS: 1003 W. Balt

IMPORTANT. See instructions on back of certificate. Name must be stated EXACTLY. PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPATION is very

Spec. 1-10-21 M&T 1500 blks.

D73399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73399

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 Stinson ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Emil

(a) RESIDENCE NO. 316 Stinson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 42 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Eliza Emil

6 DATE OF BIRTH (month, day, and year): Aug 10 - 1846

7 AGE. Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer): 0/5

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Emil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Emil

(Address): 3803 Thames St.

15 Filed ..... 19 ..... Registrar: Robert P. Harrison, Burial Permit Clerk.

R 5-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 3. 1923

17 I HEREBY CERTIFY, That I attended deceased from May ..., 1922 ... to March 3 ..., 19 23 ..., that I last saw him alive on March 3 ..., 19 23 ..., and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis,

(duration) 1 1/2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Coronary Endarteritis

(duration) 1 yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Marx, M. D.

3. 4. 1923 (Address) 801 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Laurel — DATE OF BURIAL: Mar 6 1923

20 UNDERTAKER: George L. Schwab — ADDRESS: 1501 Park Ave.

IMPORTANT: Fill in all items so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73400 ~~D73400~~

142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Akers

(a) RESIDENCE NO. 1 W. Henrietta St. ST., ...WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Akers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah Ann Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Municipal Hospital Records.

(Address) Robert P. Harrison,

5-~~14~~-1923 ..., 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 2, 19 23, to March 4, 19 23, that I last saw her alive on March 4, 19 23, and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Fibro-adenoma Right Breast

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Bronch. Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-22-23

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) Clyde A. Reed, M. D.

3-5-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 8 1923
20 UNDERTAKER	ADDRESS
John H. Denny	715 Light St

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Benign

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73401

CERTIFICATE OF DEATH.

124 D73401

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 Mangold ST. 21 WARD)

2-FULL NAME Jefferson L. B. Schweigart

(a) RESIDENCE NO. 839 Mangold ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced; (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa J Schweigart

6 DATE OF BIRTH (month, day, and year) Jan 2 1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
60	2	1	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) Saturday Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Maryland

PARENTS

10 NAME OF FATHER L. Schweigart

11 BIRTHPLACE OF FATHER (city or town) Westminster (State or country) Maryland

12 MAIDEN NAME OF MOTHER A. Markers

13 BIRTHPLACE OF MOTHER (city or town) Westminster (State or country) Maryland

14 Informant (Address) Mrs Louisa J Schweigart 839 Mangold

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to March 3, 1923, that I last saw h[illegible] alive on March 1, 1923, and that death occurred, on the date stated above, at 6½ a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) — yrs. 4 mos 1 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edw Coventhen, M. D.

Mar 5 1923 (Address) 517 Cath St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL March 6 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

IT IS VERY IMPORTANT that it may be properly classified. PHYSICIANS should state exactly what is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D73402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73402

CERTIFICATE OF DEATH.

94

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Elizabeth Mair .....

(Residence in Baltimore: No. 819 AShland Ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	single

6-DATE OF BIRTH. July 20/22, 1..... (Month) (Day) (Year)

7-AGE. ..yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or ...min.: none

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles Mair

11-BIRTHPLACE OF FATHER, (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER, Willy Johnson

13-BIRTHPLACE OF MOTHER, (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Hill (Grandmother)

(Address) 819 Ashland Ave.

15- MAR 23 1923 1923

Robert F. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 3/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus - Rickets
Dilated Heart
(Autopsy at hospital)

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. S. H. Cullen M. D. (Coroner.)

3/3/23 192.... (Address) 508 E. North

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel DATE OF BURIAL. Mar 26 1923

20-UNDERTAKER, Caspar Alexander ADDRESS Druid Hill & Ed

Instructions on back of certificate. Exact statement of OCCUPATION should be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D73403

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73403

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3238 Fulton St.: 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis E. Jackson

(Residence in Baltimore: No. 3238 Fulton St.; 44 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mar 5, 1923 (Month) (Day) (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), Cumberland Md.

PARENTS.

10-NAME OF FATHER, Nathaniel Jackson

11-BIRTHPLACE OF FATHER (State or Country), Norway

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ida M. Jackson

(Address) 3238 S. Fulton Ave

15- Filed ..... 191..... Robert F. Harrison. Burial Permit Clerk. Registrar.

1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH March 5, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 24 1923, to Mch 5-7 1923, that I saw him alive on Mch 4-7 10 P M 191..., and that death occurred, on the date stated above, at 5:35 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

3-5, 1923 (Address) 3320 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Mch 6, 1923
20-UNDERTAKER	ADDRESS
Geo. J. Smith	1538 Hollins Ave

Exact statement of OCCUPATION is very important. Incorrect or indefinite statements cannot be accepted for record. Physician will please write plainly and fill out every item of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73404 D73404

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 S Chapel ST.; W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta A Stanley

(Residence in Baltimore: No. 502 S Chapel St.; 51 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, August (Month) 31st (Day) 1856 (Year)

7-AGE, 66 yrs. 6 mos. 7 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Henry Young

(Address) 502 S Chapel St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1922, to March 4, 1923, that I saw h[illegible] alive on March 4, 1923 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Abt [illegible] (Duration) One yrs. — mos. — da.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — da.

(Signed) [illegible] M. D.

4-3-23, 1923 (Address) 2100 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Mar. 6, 1923.

20-UNDERTAKER Peter Nicolaus

ADDRESS 2060 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73405

CERTIFICATE OF DEATH.

101-001

D73405

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 836 McKim ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Ennis

(a) RESIDENCE. NO. 836 McKim ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Evans Ennis.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) md
(State or country)

PARENTS

10 NAME OF FATHER Thos. B. Cole

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Walus

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Evans Ennis
(Address) 836 McKim St

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to Mar 4, 1923, that I last saw h[illegible] alive on Mar 3, 1923, and that death occurred, on the date stated above, at 6 50 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Dotennia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J Edward Fisher, M. D.

3-4 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Mar. 6 1923
20 UNDERTAKER	ADDRESS
Chas. R. Johnson	467 N. Carlton

Should state OCCUPATION. Exact statement of OCCUPATIONS may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73406

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William C. Bell

(a) Residence No. 702 E. 22nd St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) ? ? 1866.

7-AGE. 56 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Steward

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Bell

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Margaret Bowles

13-BIRTHPLACE OF MOTHER (city or town) Balto.
(State or Country), Md.

14- (Informant) Mrs. John F. Hickes

(Address) 702 E. 33rd St.

15- Filed MAR 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 5 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 18 1923 to Nov. 5 1923

that I last saw h[illegible] alive on Nov. 5 1923

and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows: Carcinoma Sigmoid ?

operation Left Colostomy Left Lumbar

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebrovascular Dis

Status Rheumaticus (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 22 1923

Was there an autopsy? No

What test confirmed diagnosis? Oper. findings

(Signed) [illegible] M.D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL. Nov. 7 1923

20-UNDERTAKER. Wm. E. Black ADDRESS 922 N. Broadway

Duplicate Certificates.

Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73407

D73407

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 S. East Ave. ST., 76 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvina Phipps

(a) RESIDENCE NO. 312 S. East Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert F. Phipps

6 DATE OF BIRTH (month, day, and year) April 13, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

027

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Fiege

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Reuter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Robert F. Phipps
(Address) 312 S. East Ave.

15 MAR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/23.

17 I HEREBY CERTIFY, That I attended deceased from 2/25, 1923, to 3/3, 1923, that I last saw her alive on 3/3, 1923, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Reifschneider, M. D.

3/5, 1923 (Address) 2939 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Mch. 6, 1923
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway,

IT IS very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified, so that it may be coded EXACTLY; PHYSICIANS should state

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73408

CERTIFICATE OF DEATH.

117 D73408

REGISTERED NO.

1-PLACE OF DEATH Church Home

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Armstrong

(a) RESIDENCE No. 601 S. Ellwood ave ST., Balto WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Louise Armstrong

6 DATE OF BIRTH (month, day, and year) Oct. 7 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	49	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Ship building

(c) Name of employer Baltimore Dry Dock Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edward A. Armstrong

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Regina B. Hall

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Cecil Co. Md.

14 Informant S. F. Armstrong

(Address) 627 East 33rd St.

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21 1923, to March 4 1923, that I last saw h~~im~~ alive on 1.34 P.m. 1923, and that death occurred, on the date stated above, at 1.35 P.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Keith C. Rice, M. D.

19 (Address) Keith C. Rice Church Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	March 7 1923

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

(over)

IMPORTANT. See instructions on back of certificates. PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73409 146 D73409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Joseph's Hospital ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Minnies

(a) RESIDENCE. NO. 1721 Atkinson Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 8yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Minnies

6 DATE OF BIRTH (month, day, and year) 11-11-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Wm J. Wessel

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Louisa Atkinson

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Edward M. Minnies (Address) Reisterstown Md Arlington

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1923, to March 5, 1923, that I last saw h.. alive on March 5, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) George L. Wessel, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 3/8 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

IMPORTANT. PHYSICIANS should state name of informant may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D73410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73410

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Park Ave ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Bass

(a) RESIDENCE NO. 1613 Park Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) April 27th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER E. W. Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Ferguson
(Address) 1613 Park Ave

15 MAR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1922, to March 5 1923, that I last saw h[illegible] alive on March 5 1923, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Uremia Sclerosis
Nephritis Chronic
Myocardial Insufficiency
Contracted (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis
(duration) yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes. Agonal Hemorrhage

What test confirmed diagnosis Albumin and Casts

(Signed) C. B. Gamble Jr, M. D.

, 19 (Address) 2627 Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL March 6 1923

20 UNDERTAKER Henry H Jenkins Son Co — ADDRESS Orchard & Gilmor Sts

IMPORTANT. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATIONS on back of certificates. See instructions on back of certificates. Items are very important.

Spec.—1-10-21—M&T—1500 Bks.

D73411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101-00

D73411

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 217 N. Mount Street ST., 19 WARD)

2-FULL NAME Mary Ann Mason

(a) RESIDENCE NO. 217 N. Mount St. ST., ... WARD Washington D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER Wallace E. Mason

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Montreal Can.

12 MAIDEN NAME OF MOTHER Ella Enty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pittsburge Pa.

14 Informant Wallace E. Mason
(Address) 217 N. Mount St.

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/23 19

17 I HEREBY CERTIFY, That I attended deceased from 3/3/'23 , 19 .. to 3/4/'23 , 19 ....

that I last saw her alive on 3/4/'23 , 19 ....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Bilateral)

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson. M. D.

, 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Mar 6 1923.
20 UNDERTAKER	ADDRESS 322
Mrs. Katie R. Williams	N. Schroeder St

IMPORTANT.—PHYSICIANS should state name of disease so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

15900 E
D73412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73412

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Strange.

(a) RESIDENCE No. 505 Bloom St. East, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~(b) HUSBAND of~~ ~~(or) WIFE of~~ (Parents)

6 DATE OF BIRTH (month, day, and year): Walter & Mary Strange

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): (illegible)

(c) Name of employer: (illegible)

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Walter Strange

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL.

15 MAR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1922 to March 5 1923.

that I last saw him alive on March 5, 1923,

and that death occurred, on the date stated above, at 12.25 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous Empyema.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 1922

Was there an autopsy? yes Jan 4 1923

What test confirmed diagnosis? Autopsy

(Signed) C. H. Duncan M.D.

3/5, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Mar 6th 1923

20 UNDERTAKER: Hanna E. Wright — ADDRESS: Hopkins

PHYSICIANS should state Exact statement of OCCUPA

It may be properly classified. See instructions on back of certificates.

very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73413

CERTIFICATE OF DEATH.

D73413

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3195 Stricker ST.; 14 WARD)

2-FULL NAME Josephine Easton

(a) RESIDENCE. NO. 319 S. Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Dahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Wanda Easton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Josephine Easton
(Address) 319 S. Stricker St

15 Filed MAR. 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/23 19

17 I HEREBY CERTIFY, That I attended deceased from 2-5-23, 19..., to 3/4/23, 19..., that I last saw h... alive on 3/2/23, 19..., and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Broncho (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 3195 Stricker

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

3/5/23 (Signed) [illegible] M. D.

(Address) 1302 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	3-6- 1923
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Pa ave

...ay be properly classified. Exact statement of OCCUPA-
...k of certificates.
...important. See instructions on back of

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73414

CERTIFICATE OF DEATH.

101-001 D73414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 3 WARD)

2-FULL NAME Dora Shroman

(a) RESIDENCE NO. 1149 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27-1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	14	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Chas Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sophia Gold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore St

MAR 6 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1923, to March 5, 1923,

that I last saw h. alive on March 5, 1923,

and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Moses Gellman M. D.

Mar 5, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Rm

DATE OF BURIAL 3/6 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

THAT it may be properly classified. Exact statement of OCCUPATIONS on back of certificates.

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73415

CERTIFICATE OF DEATH.

11-001

D73415

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1443 Andre ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Woznalis

(Residence in Baltimore: No. 1443 Andre St.; 32 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Noknow (Month), 1 (Day), (Year)

7-AGE, 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) No

9-BIRTHPLACE, (State or Country) Russia (Lithuania)

PARENTS.

10-NAME OF FATHER, Kazimer Woznalis

11-BIRTHPLACE OF FATHER (State or Country), Lithvania

12-MAIDEN NAME OF MOTHER Noknow

13-BIRTHPLACE OF MOTHER (State or Country), Lithvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agta Woznalis

(Address) 1443 Andre Street

15- Filed MAR 6 - 1923, 191 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4 (Month) (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1923, to March 4 1923, that I saw h— alive on March 4 1923, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) E. J. Kean M. D.

3-7, 1923. (Address) 50 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross A.A. DATE OF BURIAL, March 7th, 1923

20-UNDERTAKER John Grebliauckas ADDRESS 425 S Paca St.

JB

Spec.—8-24-14—M. & T.—2000 Blks.

D73416 HEALTH DEPARTMENT—CITY OF BALTIMORE

D73368 CERTIFICATE OF DEATH. 101-001 D73416

1-PLACE OF DEATH 3rd Ave y 4th St REGISTERED No. C

CITY OF BALTIMORE: (No. 3rd av. Fairfield ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Burns

(Residence in Baltimore: No. 3rd av. Fairfield St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, [illegible] January (Month) ..., 1885. Feb 20 (Day) (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or mts.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Laber

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country), North Calorna

PARENTS.

10-NAME OF FATHER, James Burns

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Nettie Green

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie Burns

(Address) 3rd ave Fairfield Md

15- MAR 5 1923 Filed ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 1 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1923, to Feb 28 1923, that I saw him alive on Feb 28 1923, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Passed away Gen. Debility

Place of Work (Duration) yrs. mos. ds.

(Signed) W. H. Oleson M. D.

Mch 2, 1923 (Address) 2037 McElderry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Mar 5, 1923

20-UNDERTAKER P. C. Gross ADDRESS 1400 McElderry

Remarks Dr. Goldman ... to gas attack Burns' window ... was overcome by illuminating gas June 1922.

No Inquest necessary. Otto Reinhardt M.D. Coroner

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Blks.

D73417 HEALTH DEPARTMENT—CITY OF BALTIMORE D73417

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 886 Pierce ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Banks

(a) RESIDENCE No. 886 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Joe Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Tyzzie Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant John Marks 886 Pierce

(Address)

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to March 5, 1923, that I last saw h alive on March 4, 1923 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Mch 6 1923 (Address) 709 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Mar 7 1923

20 UNDERTAKER R. C. Groth ADDRESS 1405 McElderry

IMPORTANT.—PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73418

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73418

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1800 N. Bond St. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha E. Mobray

(Residence in Baltimore: No. 1800 N. bond St.; yrs., 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word)
female	white	married

6-DATE OF BIRTH, July 6/23 1.....
(Month) (Day) (Year)

7-AGE, 24 yrs. 6 mos 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Theodore ALT

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, ANNA SCHELLENBERGER

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna ALT

(Address) 1800 N. Bond St

15- FILED MAR 6 - 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, MARCH 3/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Multiple Neuritis 6 months

Dermato-myositis (Duration) ....yrs. ....mos. ....ds.

(Signed) J S Woodall M. D.
(Coroner.)

3/6/23 192 (Address) 508 E. North Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cemtg — DATE OF BURIAL, March 6 1923

20-UNDERTAKER, Geo J Ruth — ADDRESS 1735 Hoffad ave

Instructions: See instructions on back of certificate. Exact statement of OCCUPATION should be properly classified.

Spec.—1-10-21 M&T 1500 Blks.

D73419 HEALTH DEPARTMENT—CITY OF BALTIMORE 29 D73419

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Izeslor Rychinsky

(a) RESIDENCE NO. 218 S. Eutaw ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Nicodemus Rychinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER (Helen) Baronas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Helen Rychinski

(Address) 218 S Eutow Street

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 4 1923

17 I HEREBY CERTIFY, That I attended deceased from 2 - 13, 1923, to 3 - 4, 1923, that I last saw him alive on 3 - 4, 1923, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Extensive 3rd degree burns

(duration) yrs. ... mos 17 ds.

CONTRIBUTORY (Secondary) Tetanus

(duration) ... yrs. ... mos. 4 ds.?

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Milton C Lang M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rédeermer	March 7. 1923

20 UNDERTAKER	ADDRESS
John Grebliauckas C.D.	425 S Paca St

IT IS Very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D73420

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 505 N. Gilmor ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Cecilia Valentine

(a) RESIDENCE. No. 505 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Henderson Valentine

6 DATE OF BIRTH (month, day, and year) Unknown 1874
(month & day)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Doc Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Henderson Valentine
(Address) 505 N. Gilmor St

15 FILED MAR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1923, to March 3, 1923, that I last saw h[illegible] alive on March 3, 1923, and that death occurred, on the date stated above, at 4 50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? Exam.

(Signed) John D. Quinn, M. D.

3/5, 1923 (Address) 1501 N. Dulton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	March 6 1923
20 UNDERTAKER	ADDRESS
John H. Godwin	142 White St

Important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73421

1-PLACE OF DEATH

CERTIFICATE OF DEATH

90 D73421

Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F Daley

(Residence in Baltimore: No. 2427 Eagle Place St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Oct 24 - 59 (Month) (Day) (Year)

7-AGE. 63 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Baker
(b) General nature of industry, business, or establishment in which employed (or employer). Rice Bros.

9-BIRTHPLACE, (State or Country). City

PARENTS.

10-NAME OF FATHER. Frederick Lang

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma L. Long

(Address) 2427 E Eager St.

15-Filed MAR 6 - 1923 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Mar 3 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 1 yr. 2 mo.

CONTRIBUTORY (Secondary)

(Signed) G. Clinton Baker M. D.

(Coroner) May 23 1923 (Address) 1173 E Eager

*Primary Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore	3/6/23
20-UNDERTAKER. Philip Hennig	ADDRESS 2016 Orleans

Filed with Registrar of Vital Statistics. See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

Addessie Clay.

D73422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73422

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 N. Bond ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otsie Clay

(a) RESIDENCE. No. 809 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Clay

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 070

9 BIRTHPLACE (city or town) (State or country) Charlottesville Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Francis Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Archie Clay
(Address) 1305 Stricker

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22 - 1922, to Mar. 1 - 1923, that I last saw her alive on Mar. 1 - 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) about — yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. Injuries

(Signed) Chas. L. McCurdy, M. D.

3-5-1923 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mch 6 1923
20 UNDERTAKER	ADDRESS
Wm H Grace & Son	1400 Mosher

Important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D73423

CERTIFICATE OF DEATH.

224-001

D73423

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 W. Hughes ST.: ..... WARD)

2-FULL NAME Mary A. Moore

(Residence in Baltimore: No. 106 W. Hughes St.; 71 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1852 (Year)

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Oliver Bordley

(Address) 1106 W. Hughes St

15-

Filed MAR 6 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 28 1923, to March 4 1923, that I saw h.r alive on March 4 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: Paralysis Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Do Do

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) C. H. Knox M. D.

Mar 5, 1923 (Address) 1125 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Lawn | DATE OF BURIAL, March 6, 1923

20-UNDERTAKER Wm. H. Chase & Son | ADDRESS Mrs Mosher

Duplicate statement of OCCUPATION is very important. EXACT statement of OCCUPATION is very important. Duplicate of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73424

CERTIFICATE OF DEATH.

135 D73424

REGISTERED NO.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hosp.

CITY OF BALTIMORE: (No. Monument & Ratford ST., 8 WARD)

2-FULL NAME Chas F Berndt

(a) RESIDENCE No. 1236 N Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Berndt

6 DATE OF BIRTH (month, day, and year) Aug 14 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm Berndt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Herbert F. Berndt

(Address) 1236 N. Broadway

15 MAR 6-1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 16th, 1923, to March 4, 1923, that I last saw h[illegible] alive on March 4th, 1923, and that death occurred, on the date stated above, at 4:35 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Edema

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Gen'l Arteriosclerosis 2 Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Suprapubic Prostatectomy 2/21/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Adler, Jonathan Meyer M. D.

19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	March 6 1923
UNDERTAKER	ADDRESS
John O Mitchell	1201 N. Fayette

IMPORTANT. PHYSICIANS should state name, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73425

CERTIFICATE OF DEATH.

118-002

D73425

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 70 (WARD)

2-FULL NAME Mrs Eugenia Siepel

(a) RESIDENCE NO. 139 San Catherine St ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Siepel

6 DATE OF BIRTH (month, day, and year): April 3, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51 -		11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Herman Siepel 139 San Catherine St

15 MAR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from 1 P.m. March 5, 1923, to March 5, 1923.

that I last saw her alive on March 5, 1923.

and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 5/23

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edward H. Kutlowski, M. D.

, 19 (Address) St Agnes Hospital City.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: Mar 8 1923

20 UNDERTAKER: Mr & Mrs John W. Teufel & Son — ADDRESS: 801 W. Fayette

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73426

100-001

CERTIFICATE OF DEATH.

D73426

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 W. Cross St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. R. Bramsby

(Residence in Baltimore: No. 19 W. Cross St.: 1 yrs., 2 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	~

6-DATE OF BIRTH, Dec 26, 1921
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION,
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm. Becker

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Myrtle Carter

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) John Bramsby

(Address) 19 W Cross st

15-

Filed MAR. 6 - 1923, 19.. ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 4th, 1923, to March 4th, 1923, that I saw him alive on March 4th, 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-pneumonia
(Acute Congestive Type)
..... (Duration) 1 yrs. 1 mos. 8 days

CONTRIBUTORY (Secondary) Cerebral Sclerosis
..... (Duration) yrs. mos. 7 days

(Signed) Harry Keebel M. D.

3/6, 1923 (Address) 1324 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Western Cem	Mar 8, 1923
20-UNDERTAKER	**ADDRESS**
F. A. Krause & Son	703 Hanover

Fold here and paste on back of certificate.

Statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Blks.

D73427 HEALTH DEPARTMENT—CITY OF BALTIMORE D73427

CERTIFICATE OF DEATH.

91-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Pennsylvania Ave ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham T. Oppenheim

(a) RESIDENCE NO. 714 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Oppenheim

6 DATE OF BIRTH (month, day, and year) March 1 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 645

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jeremiah Oppenheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Oakrolin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Jerome Oppenheim (Address) 714 Penna. Ave.

15 Filed MAR. 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 1 1923 to March 4 1923, that I last saw him alive on March 4, 1923, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows: Uremia - Sclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) J. Whitridge, M. D.

, 19 (Address) 3 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 3/7/ 1923

20 UNDERTAKER David Sandheim

ADDRESS 118 W. Mt. Royal Ave

THAT IS VERY important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D73428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73428

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 Brookfield Ave. WARD) 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Davidson

(a) RESIDENCE No. 2301 Brookfield St., Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Leis Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Hegedorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Isaac Davidson

(Address) 2301 Brookfield Ave

15 Filed MAR 6 - 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/ 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to March 5, 1923.

that I last saw h— alive on March 5, 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Grippe

Lobar Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia & Grippe

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H B Wolf, M. D.

19 (Address) 113 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Hebrew Cem.

DATE OF BURIAL 3/7/ 1923

20 UNDERTAKER David Sondheim

ADDRESS 118 W. Mt. Royal Ave

IMPORTANT: Physicians should state name of disease causing death, as this may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73429 ✓ 90 D73429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. FORT MCHENRY, BALTO.,MD. ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME KERR, James

(a) RESIDENCE No. 4111 Belleview Ave., Balto.,Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of XXXXXX --

6 DATE OF BIRTH (month, day, and year) --

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	-	-	-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Surveyor

(b) General nature of Industry, business, or establishment in which employed (or employer) ..... -- 8 6

(c) Name of employer ..... Unknown

9 BIRTHPLACE (city or town) (State or country) ..... -- Maryland

PARENTS

10 NAME OF FATHER Wm Unknown Kerr

11 BIRTHPLACE OF FATHER (city or town) (State or country) ..... -- Unknown

12 MAIDEN NAME OF MOTHER ..... Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ..... -- Unknown

14 Informant ..... Hospital Records.

(Address) ..... Fort McHenry, Baltimore, Md.

15 Filed MAR 6 - 1923 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 29, 19 21 to March 4, 1923, that I last saw him alive on March 4, 1923, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute parenchymatous nephritis.

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Cardiac Valvular disease, mitral insufficiency. (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical History & Laboratory records.

(Signed) [illegible] Surgeon (R), M. D.

3/5. 1923 (Address) Fort McHenry, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cemet	3/6. 1923
20 UNDERTAKER H. Lennon & Bro	ADDRESS 1127 E. Baltimore

PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates. This certificate, to be legal, must be properly classified. It may

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73430

CERTIFICATE OF DEATH.

101-001

D73430

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 Warner ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garafelia Fletcher

(a) RESIDENCE No. 828 Warner ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edwin Fletcher

6 DATE OF BIRTH (month, day, and year): May [illegible] 48

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Mr Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mr Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Rose Fletcher Ringold

(Address): 827 Warner St

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/3/ 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923 to March 3, 1923, that I last saw her alive on March 3, 1923, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno A Robinson M. D.

3/4/1923 (Address) 1500 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lubrun Cemetery — DATE OF BURIAL: March 6 1923

20 UNDERTAKER: W M Rowton — ADDRESS: 223 E N Monument

IMPORTANT: PHYSICIANS should state name, residence and occupation so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73431

CERTIFICATE OF DEATH.

162

D73431

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 501 E Gittings ST.: (or WARD) 24

2-FULL NAME Mrs. Edward Dufour Phillips

(a) RESIDENCE. No. 501 E Gittings St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Wid

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3.5.73

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edgar F. Phillips

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Trinkle

13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) Md

14 Informant Mrs. Edgar F. Phillips
(Address) 501 E Gittings St

15 MAR 6 - 1923 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.5. 1923

17 I HEREBY CERTIFY, That I attended deceased from 3.5 1923, to 3.5 1923, that I last saw h— alive on 3.5 1923, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

From Birth. Lived 1 yr. 1 mo. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What tests confirmed diagnosis? —

(Signed) L. Livingston, M. D.

, 19 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	May 6 1923
20 UNDERTAKER	ADDRESS
Margaret T. Flynn	1722 Light St.

Be sure that all questions are properly answered. Exact statement of OCCUPATIONS should state particularly what each person does in his trade or profession. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73432

CERTIFICATE OF DEATH.

11-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Ratigan

(a) RESIDENCE. NO. 303 Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) about 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Andrew J. Ratigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Hospital Record

(Address)

15 Filed MAR 6 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4. 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1923 to March 4. 1923

that I last saw h alive on March 3. 1923.

and (that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S & S.

(Signed) John J. Kruger, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	March 7 1923
20 UNDERTAKER Margaret S. Flynn	ADDRESS 1422 Light

Very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

SWAN

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73433 ✓ 74-60 D73433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1815 N Port ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm F Swan

(a) RESIDENCE NO. 1815 N Port ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced~~, (write the word)
Male	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 13 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bremen

PARENTS

10 NAME OF FATHER William Swan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Celia Cotton

(Address) 1825 N Port st

15 MAR 6 - 1923 ROBERT R. KRAUER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Mar 3, 1923,

that I last saw h alive on Mar 3, 1923,

and that death occurred, on the date stated above, at 12 41 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible], M. D.

Mar 6 1923 (Address) 1301 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL March 6 1923

20 UNDERTAKER Robt J Turner Sons — ADDRESS 1442 N Broadway

IT is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73434

CERTIFICATE OF DEATH.

31 D73434

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 9 WARD)

2-FULL NAME Thomas Daniel

(a) RESIDENCE NO. 3545 Old York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900 Sept 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Howard T. Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records

(Address) M. T. H.

15 MAR. 6-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1923, to March 5, 1923,

that I last saw him alive on March 5, 1923,

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis and enteritis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalyliecce M. D.

3-5-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: North End Va,

DATE OF BURIAL: 3/7 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Watt

IT IS VERY IMPORTANT. See instructions on back of certificates. PHYSICIANS should state exactly, so that it may be properly classified. Exact statement of OCCUPATION

D73435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D73435

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 S. Kenwood Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Enoch S. Hartlove

(Residence in Baltimore: No. 911 S. Kenwood Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: Sept. 8th 1854 (Month) (Day) (Year)

7-AGE: 68 yrs. 5 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brickmaker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): Balto.

PARENTS:

10-NAME OF FATHER: John Hartlove

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unkenard

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Hartlove

(Address) 614 N Ellwood

15- Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3rd 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Unknown ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) Yrs. Mos. ds.

(Signed) Jno. B. Horton M. D. Coroner.

March 5 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal. Death. No

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland DATE OF BURIAL, March 7

20-UNDERTAKER, Tom Cook ADDRESS 502 Hartlan

See instructions on back of certificate. Physicians should be properly classified. Exact statement of OCCUPATION may be necessary.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73436

CERTIFICATE OF DEATH.

D73436

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4 Ward) 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Chas F. Logan

(Residence in Baltimore: No. unknown St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. ..... (Month) 9 (Day) 1850 (Year)

7-AGE. 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ret

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Wm Logan

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Adeline Smailes

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo H Zieglar

(Address) 137 - 12 St Wash DC

15 FILED MAR 6 - 1923 ROBERT R. KRAUTER, Burial Permit Officer. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch 4 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coping Due to Accumulating
yr
Mucus & Edema
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Mch 6 1923 (Address) 1609 Bcm

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hagerstown Md.	Mar 6 1923

20-UNDERTAKER.	ADDRESS
Wm Cook	502 E Fort Ave

W. M. R.R. c/o Geo H Zieglar

See instructions on back of certificate. Causes improperly classified. Exact statement of OCCUPATION and CAUSE OF DEATH necessary. PHYSICIANS should

Spec.—1-10-21—M&T—1500 Blks.

161838

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D73437

D73437 CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

2-FULL NAME Boy Jennings

(a) RESIDENCE NO. 1206 N. Spring St. City WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20 1923.

7 AGE Years Months Days 8 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1923, to Feb. 22, 1923, that I last saw him alive on Feb. 22, 1923, and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. Life mos. ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Born at home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. A. Reed, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Health Commissioner MAR 5 - 1923

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. PHYSICIANS should state plainly the CAUSE OF DEATH. Certificates of death must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

161526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73438 CERTIFICATE OF DEATH. 113 D73438

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St., 18 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wilhelm

(a) RESIDENCE NO. 837 Hollins St (St., ... Ward .....)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 MAR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 2, 1923, that I last saw h.. alive on March 2, 1923, and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal indigestion (vomiting)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) X Type

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. A. Weed, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

MAR 5 - 1923

PHYSICIANS should state very carefully, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73439

CERTIFICATE OF DEATH.

101-001

D73439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 S Collington Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Perkins

(a) RESIDENCE NO. 246 S Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Thos. Perkins

6 DATE OF BIRTH (month, day, and year) Dec. 8-1838

7 AGE | Years 84 | Months 2 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/ 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 18, 1923, to May 3, 1923, that I last saw her alive on May 3, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Hamilton Dean, M. D.

, 1923 (Address) 3028 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address) Mrs. John O'Donnell 246 S Collington Ave

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 3/7/ 1923

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E Baltimore

PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-
See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73440

CERTIFICATE OF DEATH.

124

D73440

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Agnes Lindsay

(a) RESIDENCE NO. 104 N. Lakewood Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas L. Lindsay.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	✓	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. Work

(b) General nature of Industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Veatter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mayland

12 MAIDEN NAME OF MOTHER Mary Huggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Univ. Hospital Records (Address)

15 FILED MAR 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/2, 1923, to 3/4, 1923, that I last saw her alive on 12~~4~~ 3/4, 1923, and that death occurred, on the date stated above, at 12:45 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Fracture

Cholecystectomy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia.

(duration) yrs. mos. 1 da.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? Yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M Hallerton, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 3/7 1923

20 UNDERTAKER: John A. Moran — ADDRESS: 3000 E. Balto St.

IMPORTANT.—Certificate of death may be properly classified. PHYSICIANS should state exact statement of OCCUPATION. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer. Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Removal of Gall Bladder

Spec.—1-10-21—M&T—1500 Bks.

D73441 HEALTH DEPARTMENT—CITY OF BALTIMORE D73441

CERTIFICATE OF DEATH. 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 N. Wolf ST., 7 WARD)

2-FULL NAME Thos J. Dougherty

(a) RESIDENCE NO. 730 N Wolf ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret J Dougherty

6 DATE OF BIRTH (month, day, and year): Dec 28/76

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	46	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machine Helper

(b) General nature of Industry, business, or establishment in which employed (or employer): Balto Copper Works

(c) Name of employer: 086

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael J Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret J. Dougherty. (Address): 730 N. Wolf St

15 Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1922, to March 5, 1923, that I last saw him alive on March 3, 1923, and that death occurred, on the date stated above, at 5. 0. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) John D. Furby, M. D.

3/5. 1923 (Address) 8522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 3/8 1923

UNDERTAKER: John A. Moran — ADDRESS: 3000 E Balto St.

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73442

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 South Ann ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME PETER BOGDAN,

(a) RESIDENCE No. 113 South Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 45 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Bogdan,

6 DATE OF BIRTH (month, day, and year) May 9. 1868.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boland,

PARENTS

10 NAME OF FATHER Walenty Bogdan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary **********

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Rosa Bogdan, (Wife)

(Address) 113 So. Ann Street

15 MAR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4. 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 3 — 1923, to March 4 — 1923, that I last saw h— alive on March 4 1923, and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia — Bronchitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A Morgan, M. D.

, 19 (Address) 125 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL MAR 8 - 1923 19

20 UNDERTAKER W. J. Sadowski

ADDRESS 705 S. Ann st

PHYSICIANS should state PRECISELY: Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73443

CERTIFICATE OF DEATH.

101-001

D73443

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1723 Hudson St. ST., 1 WARD)

2-FULL NAME Mary Jane Raftery

(a) RESIDENCE NO. 1723 Hudson ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Martin Raftery.

6 DATE OF BIRTH (month, day, and year) - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitress

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Richard Hogg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Woods

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Anna Steinhoff
(Address) 902 S. Bonsey St

15 Filed MAR 8 1923 . 19 ROBERT R. KRAUTER,
Burial ~~Permit Clerk.~~ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 1 , 1923 , to March 3 , 1923 ,
that I last saw h alive on March 3 , 1923 ,
and that death occurred, on the date stated above, at 10.55 a. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank A. Jamieson M. D.

3/5 . 1923 (Address) 2431 Fait Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL March 6 1923.

20 UNDERTAKER Lilly Ed Zeiler

ADDRESS 1038 Wolfe St.

IMPORTANT: Physicians should state on this certificate the exact cause of death in such manner that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73444

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

179 D73444

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 738 S. Potomac St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Most.

(a) RESIDENCE NO. 738 S. Potomac St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John Most.

6 DATE OF BIRTH (month, day, and year) Jan. 20 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James B. Taylor.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza J. Murphy.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Jas. Miller B. Glenn (Sister)

(Address) Colgate Md.

MAR 6 - 1923, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20 1923 to Mar 4 1923, that I last saw her alive on Mar 5 19..., and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H. Ruth Lindley, M. D.

3-6-23 19 (Address) 2458 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL March 7 1923.

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 E. Monument St.

IMPORTANT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D73445 HEALTH DEPARTMENT—CITY OF BALTIMORE D73445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 3209 Dillon ST.; 26 WARD) 7th-001 REGISTERED No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Zeberlein

(Residence in Baltimore: No. 3209 Dillon St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 12, 1854
(Month) (Day) (Year)

7-AGE, 68 yrs. 3 mos. 21 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work R.R. 613
(b) General nature of industry, business, or establishment in which employed (or employer) Conductor

9-BIRTHPLACE, (State or Country), Md

PARENTS.
10-NAME OF FATHER, John G. Zeberlein
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Zeberlein
(Address) 3209 Dillon St

15-
Filed MAR 6 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3rd, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton M. D.
(Coroner)
March 3rd, 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Natural Cause

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, March 6, 1923

20-UNDERTAKER Lilly & Zeiler ADDRESS 400 S. Wolfe St

INSTRUCTIONS.—Be careful that every blank is properly filled. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73446 HEALTH DEPARTMENT—CITY OF BALTIMORE D73446

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 N. Glover ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Battle

(a) RESIDENCE NO. 4 N. Glover ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 / 1864

7 AGE Years 58 Months 8 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fireman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Battle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah Strong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ruby Battle Daughter (Address)

15 MAR 6-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 4 1923

17 I HEREBY CERTIFY, That I attended deceased from 3 - 1, 1923, to 3 - 4, 1923, that I last saw him alive on 3 - 4, 1923, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Later Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell, M. D.

, 19 (Address) 152 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem | DATE OF BURIAL Mar 8 1923

UNDERTAKER Joseph Herr Son | ADDRESS 756 N Luzerne Ave

Print or write with pen or indelible pencil. PHYSICIANS should state carefully. Exact statement of OCCUPATION may be very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73447

HEALTH DEPARTMENT—CITY OF BALTIMORE D73447

CERTIFICATE OF DEATH.

14-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Schotts Court ST. 23 WARD)

2-FULL NAME Priscilla Laurie

(a) RESIDENCE. No. 1112 Schotts Court ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year)

7 AGE: 70 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER Hodge Laurie

11 BIRTHPLACE OF FATHER (city or town) (State or country): — — —

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant ... (Address) ...

15 Filed -1923 ... 19 ... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to March 5, 1923

that I last saw her alive on March 5, 1923

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 5 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner M. D.

19 (Address) 1273 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAR 6 1923

20 UNDERTAKER: Commissioner Health,
Per. Wm. E. WOODALL

ADDRESS

IMPORTANT. See instructions on back of certificates. PHYSICIANS should write plainly; all items must be properly classified. Exact statement of OCCUPATION may be important.

D73448

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D73448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 685 Druid St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hall

(Residence in Baltimore: No. 685 Druid St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: ..... Don't Know ..... 1.....
(Month) (Day) (Year)

7-AGE: 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 140

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: David Hall

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Liza Engel

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hodges.

(Address) 1717 Madison Ave.

15- Robert P. Harrison,

Filed ..... 192 .....

1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch (Month) 4 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Don't Know ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. K. Tompelo M. D.
(Coroner.)

3-5-23 (Address) 117 W. Madison

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn. DATE OF BURIAL: Mar. 6th 1923

20-UNDERTAKER: Leo D. Cook ADDRESS North Harford

~~the instructions on back of certificate. Exact statement of OCCUPATION~~ ~~PHYSICIANS should be properly classified.~~

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73449 ✓ D73449

CERTIFICATE OF DEATH.

X 164

D73449

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #5517-Ethelbert Av. ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME BETHIA YELLOTT ANGEVINE

(a) RESIDENCE NO. #5517-Ethelbert-Av ST., 27 WARD (Brooklyn, N.Y.)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. ? ds. How long in U. S., if of foreign birth? 84 yrs. 0 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank Angevine

6 DATE OF BIRTH (month, day, and year) Feby-20-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	84	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) New York,
(State or country) N.Y.

PARENTS

10 NAME OF FATHER Charles S. Coleman

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Sophia Yellott

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country) N.Y.

14 Informant Mrs. Bertha C. Brown (daughter)
(Address) 5517-Ethelbert-Av., City.

15 Robert P. Harrison,
Mar 7 1923, 19
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March 4 - 1923, to March 5 - 1923.
that I last saw her alive on March 5 - 1923
and that death occurred, on the date stated above, at 9. P.M.
The CAUSE OF DEATH* was as follows:

Senility

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Aug.

(Signed) E E Nichols, M. D.

3-6-1923 (Address) Pikesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooklyn, N.Y.	Mar-7-23
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE

IMPORTANT: PHYSICIANS should state exactly. Exact statement of occupa-tion may be properly classified. Exact statement of occupation so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73450

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church-Home-Infirmary ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES AUGUSTUS ROGERS Sr.

(a) RESIDENCE NO. Church-Home-Infirmary ST., 6 WARD Woodbrook, Balto. Co.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? 61 yrs. 8 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertie Ann Rogers

6 DATE OF BIRTH (month, day, and year) June-15-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) R.R. Company

(c) Name of employer B & O R.R.Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Hobbs Rogers

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Eliza Spedden

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Bertie A. Rogers (wife)
(Address) Woodbrook, Balto. Co. Md

1923 Robert P. Harlan, . 19
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1923, to March 5, 1923, that I last saw him alive on March 4, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.
Acute Appendicitis.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Date of 2/25/23

Was there an autopsy? —

What test confirmed diagnosis? Operation.

(Signed) W. G. Live, M. D.

. 19 (Address) Church Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREENMOUNT CEMETERY — DATE OF BURIAL: Mar-7-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, [illegible]) — ADDRESS: 108 W. NORTH AVE.

IT IS very important that it may be properly classified. PHYSICIANS shall state exactly what is meant. Exact statement of OCCUPATION on back of certificates. See instructions on back of certificates.

Moquette

D73451

HEALTH DEPARTMENT--CITY OF BALTIMORE

D73451

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1137 Argyle Ave St. 17 WARD)

(If death occured in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Josephine Ernestine Moquette

(Residence in Baltimore: No. 1137 Argyle Ave St.: Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug. 16, 1864 (Month) (Day) (Year)

7 AGE: 59 yrs. 6 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: John E Hurst

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Eleanor H Hurst

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eleanora G. Hurst

(Address) 1137 Argyle ave.

15.

Filed 1923

Robert P. Harrison,
REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mch 4, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 28, 191 , to Mch 4 1923

that I saw h alive on Mch 3, 1923

and that death occurred on the date stated above, at 9 a m

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. 1 mos. ds

(Signed) C. K. Hurst M.D.

191 (Address) 841 W. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Mar. 7-1923

20 UNDERTAKER: J. W. M. Johnson

ADDRESS 1234 Eutaw St.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D73452

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1456 E. 30th St. 9 WARD)

2-FULL NAME Catherine O. Jones

(a) RESIDENCE NO. 1456 E. 30th St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. J. Jones.

6 DATE OF BIRTH (month, day, and year) January 29th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	53	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Patrick Rafferty

11 BIRTHPLACE OF FATHER (city or town) Armagh

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Dalton

13 BIRTHPLACE OF MOTHER (city or town) Wexford

(State or country) Ireland

14 Informant George E. Jones

(Address) 1456 E. 30th St.

Filed ....., 19..... Registrar

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5th 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 14th, 1923, to March 5th, 1923, that I last saw he alive on March 5th, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Epiploon Gland.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tissue exam.

(Signed) George Guthrie Tull, M. D.

3/5/23 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 3/8 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Wath

IT is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73453

CERTIFICATE OF DEATH.

11-002 D73453

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 920 Bennett Place · St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Louis Schanze Jr

(a) RESIDENCE. No. 920 Bennett Place · ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 3-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George Louis Schanze Sr

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Mary Rose

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country) Md.

14 Informant George Louis Schanze Sr.
(Address) 920 Bennett Place

15 Filed 6-1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1923, to March 6, 1923; that I last saw him alive on March 5, 1923, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Influenzal Peritonitis

22 hours.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? abdominal puncture after death

(Signed) Chester Riland, M. D.

3-6-, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Loudon Park	3/8 1923
20 UNDERTAKER	ADDRESS
W. Cook	502 E Wash St.

IMPORTANT. PHYSICIANS should state in every case the exact cause of death, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73454

CERTIFICATE OF DEATH.

90 D73454

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 250 W. Hoffman ST. 11 WARD)

2-FULL NAME Mary E. Tolon

(a) RESIDENCE NO. 250 W. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6-1842

7 AGE — Years: 80 — Months: 5 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Tolon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Julia A. Love

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Chas Lastner

(Address) 250 W. Hoffman St.

15 Filed Mch 6 1923

Robert P. Harrison,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5-1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 3, 1923, to Mch 5, 1923,

that I last saw h[illegible] alive on Mch 5, 1923,

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Senile Heart

Has been acting for quite a [illegible] but not under [illegible] care

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Cole, M. D.

, 19 (Address) 2034 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 3/8 1923

UNDERTAKER: Chas F. Evans & Son — ADDRESS: 118 W. Mt. Royal ave.

-1923

PHYSICIAN[illegible] should state that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73455

CERTIFICATE OF DEATH.

159-102 D73455

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2313 N. Calvert ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Delores O'Connor

(Residence in Baltimore: No. 2313 N. Calvert St.; Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug. (Month) 10 (Day), 1921 (Year)

7-AGE, 1 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, L. Ellwood O'Connor

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Rose Tiddy

13-BIRTHPLACE OF MOTHER (State or Country), Frostburg Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Ellwood O'Connor

(Address) 2313 N. Calvert St

15-

Filed.....Robert P. Harrison.....
Registrar.

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 2 1923, to March 5 1923, that I saw her alive on March 5 1923, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (term), malnutrition, rickets

Congenital heart disease

Cleft palate

(Duration) Since birth yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

(Signed) Lawson Helkins M. D.

March 5, 1923 (Address) 1014 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 3/7, 1923

20-UNDERTAKER, Chas. Picard & Son ADDRESS 118 W. Mt. Royal Ave

Exact statement of OCCUPATION is required. Write plainly. Should state whether employer, employee, or working on own account. Fill out all blanks. Use black ink or pencil.

Spec.—1-10-21 M&T 1500 Blks.

(See Letter attached) ✓

D73456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X34 D73456

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fitzgerald

(a) RESIDENCE NO. Philadelphia Pa. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. 7 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Fitzgerald

6 DATE OF BIRTH (month, day and year) January 15th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Locomotive Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad 073

(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER John Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Barlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.-

14 Informant Wife Elizabeth Fitzgerald (Address) 8 Eden Ct.

15 Filed ..... 19 Robert F. Harrison, Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to March 6, 1923, that I last saw h alive on March 6, 1923, and that death occurred, on the date stated above, at 8.05 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Tuberculosis of - 1st Dorsal Vertebra

(duration) 2 yrs. 3 mos. 10 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of March 6-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs-

(Signed) W. S. Jones, M. D.

3/6, 1923 (Address) Church Home Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa DATE OF BURIAL Mar 6 1923

20 UNDERTAKER Harry N. Witzke ADDRESS 1531 W Lombard

FOR IS Very important. See instructions on back of certificates. EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION

UNIVERSITY HOSPITAL

HARRY M. STEIN, M. D.
MEDICAL SUPERINTENDENT
WM. L. JORDEN
MANAGER

LOMBARD AND GREENE STREETS

BALTIMORE, MD.

March 15, 1923.

Dr. C. Hampson Jones,
Commissioner of Health,
Baltimore, Md.

Dear Dr. Jones:-

Please change the age on the death certificate of William Fitzgerald, from seventy years to sixty-six years, who died at the University Hospital on March 6th, 1923.

Yours very truly,

Kenneth B. Jones

Kenneth B. Jones, M. D.
Superintendent.

D73457 HEALTH DEPARTMENT—CITY OF BALTIMORE D73457

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1639 Friendship St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriett A. Blazakis

(Residence in Baltimore: No. 163 Friendship St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, about, 1857 (Month) (Day) (Year)

7-AGE, 72 yrs. mos. da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Basil McKinney

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt. DeLeon

(Address) 1639 Friendship

15- Robert P. Harrison,

Filed ....., 191.....

1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

carcinoma of stomach

(Duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. J. Hennessy M. D. (Coroner.)

March 6, 1923 (Address) 2 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence Annapolis Md.

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL,

St. Stephens Cemetery March 8, 1923

20-UNDERTAKER E. L. Hopkins ADDRESS Annapolis Md.

IMPORTANT. See instructions on back of certificate. Name should be stated EXACTLY. PHYSICIANS should use plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

D73458

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73458

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 S: 12th St ST. No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Amanda Lancaster.

(a) RESIDENCE NO. 614 S: 12 th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Lancaster

6 DATE OF BIRTH (month, day, and year) July 27 th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Orange Co Va

PARENTS

10 NAME OF FATHER Mason Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER ElizabethJones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Curtis C: Lancaster

(Address) 614 S: 12th St

15 Filed ....., 19.... Robert F. Harrison, Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4/23, 19.... to March 5/23, 19.... that I last saw him alive on March 5/23, 19.... and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Leg

Duration (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fulton

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Hall, M. D.

March 6/23 (Address) 1203 Eyhe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woods. Orange Co. Va

DATE OF BURIAL 3/7/23 19

20 UNDERTAKER Orange Orange Co Va John Ullrich

ADDRESS Orleans

200

IT IS VERY important. See instructions on back of certificates. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH may be required. Any information that it may be necessary to obtain should be furnished promptly.

Spec.—1-10-21—M&T—1500 Blks.

D73459

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73459

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 Gwynn Ave ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C Rupp

(a) RESIDENCE NO. 331 Gwynn Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) ydo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Rupp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bursch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward J. Rupp

(Address) 33 Gwynn Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1923

17 I HEREBY CERTIFY, That I attended deceased from 2.20, 1923 to date of death that I last saw h in alive on Mar. 4 1923 and that death occurred, on the date stated above, at 10 A.M. The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Cas 3 Days (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vincent Lundardo, M. D.

, 19 (Address) 824 N. Patterson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mar 7 1923
20 UNDERTAKER	ADDRESS
Wm Fleischmann	North Ave

IMPORTANT. PHYSICIANS should write legibly and in ink. Every item should be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73460

D73460

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2810 N Calvert ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A Bullock

(a) RESIDENCE NO. 2810 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank E. Bullock

6 DATE OF BIRTH (month, day, and year): Dec 16 1880

7 AGE — Years: 42 — Months: 2 — Days: 16 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Francis Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Martha Bunch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Frank E Bullock (Address) 2810 N Calvert

15 Filed ..... 19 ..... Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 4 1923

17 I HEREBY CERTIFY that I attended deceased from Jan 17, 1923, to March 4th 1923, that I last saw h[illegible] alive on March 3rd 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows: Endocarditis & Chr. Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): D.C. Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Diagnosis

(Signed) H. Gulick Hawes M. D.

(Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: March 6 1923

20 UNDERTAKER: W. C. Tickner & Sons — ADDRESS: North Av

FROM is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73461

CERTIFICATE OF DEATH. 11-001

D73461

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N Madeira ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Baroch

(a) RESIDENCE. No. 215 N Madeira ST., WARD.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Baroch

6 DATE OF BIRTH (month, day, and year): Oct 1850

7 AGE — Years: 74 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Frank Simanek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Kate Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): Jos Simanek 1807 Eastern Ave

15 Filed 6-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 4 19 23

17 I HEREBY CERTIFY, That I attended deceased from March 1, 19 23 to March 4, 19 23

that I last saw h alive on March 4, 19 23

and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) 3-6-23 Fred Stinger M. D.

19 (Address) 800 N Bath Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Mar 7 1923

20 UNDERTAKER: Fred Crockson

ADDRESS: 1906 Eastern Ave

...important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73462

CERTIFICATE OF DEATH.

90 D73462

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Holbrook ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Manning

(Residence in Baltimore: No. 1519 Holbrook St.; 35 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH, 3 (Month) 3 (Day), 185[illegible] (Year)

7-AGE, 65 yrs. ..... mos. ..... da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Senior C. Sullivan

(Address) 1519 Holbrook

15-

Filed ..... Robert P. Harrison, Registrar.

6-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8th 1923, to March 5th 1923, that I saw him alive on March 4th 1923, and that death occurred, on the date stated above, at 8. A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (Duration) ..... yrs. ..... mos. 11 da.

CONTRIBUTORY (Secondary) Mitral Incompetency

..... (Duration) 2 yrs. ..... mos. ..... da.

(Signed) L. M. C. Parker M. D.

March 5th, 1923 (Address) 111 W. Hartford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, 3.8. 1923

20-UNDERTAKER W M Cook

ADDRESS 502 E North

Exact statement of OCCUPATION should state whether employer, employee, or working on own account. Write plainly in ink. Do not abbreviate. Use no ditto marks. Fill all blanks. Be sure that certificate is signed and dated.

Spec.—1-10-21—M&T—1500 Bks.

D73463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73463

CERTIFICATE OF DEATH.

74-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 71 - E. Hamilton ST., 11 WARD)

2-FULL NAME Annie Fischer

(a) RESIDENCE NO. 71-E-Hamilton ST., 11 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: John Geo Fischer

6 DATE OF BIRTH (month, day, and year): Sept 3 - 1869

7 AGE: Years 53 | Months 6 | Days 0 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles Bankhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): John G. Fischer 71-E-Hamilton

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28 1923 to Mar 3 1923 that I last saw h live on Mar 3 1923 and that death occurred on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus,
Hemiplegia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) arter sclerosis x
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Chas Smith, M. D.

3/5 1923 (Address) 4756 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 3/7 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 512 E Mon St

TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73464

CERTIFICATE OF DEATH.

101-001

D73464

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1047 N. Lanvale ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa C. Brown

(a) RESIDENCE. No. 1047 N. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical

(b) General nature of industry, business, or establishment in which employed (or employer) Com. Bank

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Augustus F. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md.

12 MAIDEN NAME OF MOTHER Harriet Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Wm S. Duke (Address) 1047 N. Lanvale

15 Filed MAR 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 28 1923, to March 5, 1923 that I last saw h[illegible] alive on March 4. 1923 and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia Left lung and Apex of right lung.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. J. Story M. D.

3/6. 1923 (Address) 110 E Fourth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mch 7-1923

20 UNDERTAKER ADDRESS

John Mitchell 1231 N. Fayette

Note.—It is very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should be properly classified. Exact statement of OCCUPATIONS should state what it may be.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73465

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3507 Cedardale Rd. ST.; 15 WARD)

2-FULL NAME George A. Orth

(a) RESIDENCE: (Usual place of abode) No. 3507 Cedardale Rd. ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel S. Orth

6 DATE OF BIRTH (month, day, and year) Apr 27/1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49 years.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Compositor) 063

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. F. Orth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary E. Averbeck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mabel S. Orth

(Address) 3507 Cedardale Rd

15 MAR 7 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/23. 19

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to March 5, 1923, that I last saw h-in alive on March 5, 1923, and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Influenza - followed by Encephalitis

about 10 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Encephalitis - about

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Labratory findings

(Signed) W.S. Riblett, M. D.

3/5/23. 19 (Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	3/7/23 1923
20 UNDERTAKER	ADDRESS
John C. Mitchell	1201 W. Fayette St

MUST IS very important. See instructions on back of certificates. ...may be properly classified. Exact statement of OCCUPA... ...PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73466

CERTIFICATE OF DEATH.

D73466

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 E Lanvale ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny A. Hobbs.

(Residence in Baltimore: No. 316 E Lanvale St.; 55 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. June 15, 1868 (Month) (Day) (Year)

7-AGE. 83 yrs. 8 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country). Howard Co., Md.

PARENTS.

10-NAME OF FATHER. Washington Barnes

11-BIRTHPLACE OF FATHER (State or Country). Howard Co., Md.

12-MAIDEN NAME OF MOTHER Mary Bartholow

13-BIRTHPLACE OF MOTHER (State or Country). Howard Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) (Daughter) Elisabeth Hobbs.

(Address) 316 E. Lanvale St.

15- Filed MAR 7-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 5, 1923 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Feb 1 1923, to Mar 5 1923, that I saw h alive on Mar 5 1923, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 10 yrs. mos. da.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. da.

(Signed) Wm A Fetterolf M. D.

3/6, 23 (Address) 2714 Walbrook

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	3/8/23, 191...

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

Property classified. Exact statement of OCCUPATION is very important in case of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 D73467

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3333 Falls Road ST., 13 (WARD)

2-FULL NAME Martha A. Smith

(a) RESIDENCE NO. 3333 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Invalid

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co Md
(State or country)

PARENTS

10 NAME OF FATHER Asa. Smith

11 BIRTHPLACE OF FATHER (city or town) New York (State)
(State or country)

12 MAIDEN NAME OF MOTHER Margaret A Colson

13 BIRTHPLACE OF MOTHER (city or town) Balto Co. Md
(State or country)

14 Informant Mrs Jos Barrier
(Address) 3333 Falls Road

15 Filed MAR 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1922, to Mar 4th, 1923, that I last saw h[illegible] alive on Mar 3rd, 1923, and that death occurred, on the date stated above, at 9.05 A.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis and Chronic Interstitial Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

3/5, 1923 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar 7 1923

20 UNDERTAKER	ADDRESS
A S Marshall	359 Fall Rd

IMPORTANT. See instructions on back of certificates. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73468

58-001 D73468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No.) 109 N. Stricker ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Huber

(a) RESIDENCE. No. 109 N. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced: BUSBAND of (or) WIFE of Helen I. Richter Huber

6 DATE OF BIRTH (month, day, and year) Oct 20-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secy & Engineer Hutchinson Bros 009

(b) General nature of industry, business, or establishment in which employed (or employer): Hatter Equipment

(c) Name of employer: Hutchinson Bros.

9 BIRTHPLACE (city or town) (State or country): Maryland -

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland -

12 MAIDEN NAME OF MOTHER: Martha Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland -

14 Informant (Address): Helen I. Huber 109 N. Stricker St

15 MAR 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 25, 1923, to March 5, 1923, that I last saw him alive on March 5, 1923, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood & examination

(Signed) C. H. Ingram, M. D.

, 19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	3/8/23 19
20 UNDERTAKER: Geo. W. Sloan & Son	ADDRESS 2503 Edmondson Ave

Items 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 are very important. See instructions on back of certificates. Any person who shall wilfully refuse or neglect to furnish such information as he may be possessed of concerning any death, or who shall wilfully refuse or neglect to report the particulars required by law to be recorded in the certificate of death, or who shall report falsely or fraudulently in any case, shall be guilty of a misdemeanor, and shall be punished by a fine not exceeding fifty dollars. PHYSICIANS should state the cause of death so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73469

CERTIFICATE OF DEATH.

100-001 D73469

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 Grindall St.: 24th WARD)

2-FULL NAME Evelyn Elizabeth Chambers

(a) RESIDENCE. No. 231 Grindall St.: 24th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 14, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Walter F. Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Marie Eliz. Hettche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Walter F. Chambers 231 Grindall St.

15 FILED MAR 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1923, to March 6, 1923, that I last saw her alive on March 6, 1923, and that death occurred, on the date stated above, at 8:20 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) 0 yrs. 0 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1213 William St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	3-7 1923

20 UNDERTAKER ADDRESS

E & B Hale 1156 West St

IMPORTANT. See instructions on back of certificates. PHYSICIANS should state exact statement of OCCUPATION that it may be properly classified. Exact statement of OCCUPATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D73470

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D73470

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 N. Luzerne Ave ST.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha J. Winkelmann

(Residence in Baltimore: No. 1211 N Luzerne St.; 62 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April 5, 1846
(Month) (Day) (Year)

7-AGE, 76 yrs. 11 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Norman Mason

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Nancy Ailsworth

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John N. Winkelmann

(Address) 1615 Patterson

15-

FILED MAR 7 1923 191 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 4th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 2nd 1923, to Feb 4th 1923, that I saw h.. alive on Feb 4th 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Jno. D. Coll M. D.

Feb 6, 1923 (Address) 1202 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Mar 7, 1923

20-UNDERTAKER John F. Denny

ADDRESS 715 Light St

Exact statement of OCCUPATION is very ... should state ... of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73471
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

188-007
21

D73471
Registered No. C.....

City of BALTIMORE: (No. South Baltimore General Hospital St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Henry G. Fischer. 17 --- 5 --- 21.

(Residence in Baltimore: No. 1146 W. Cross St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White	Single.

6-DATE OF BIRTH. September 12, 1905.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
17 yrs. 5 mos. 21 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baker helper.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. William Fischer.

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Elsie A. Gakenheimer.

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elsie Fischer. (mother).
(Address) 1146 W. Cross Street.

15-
FILED MAR 7 - 1923
ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 5, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Concussion of the Brain.
Fracture of left Femur.
Accidental fall from a motor-cycle.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration).....yrs.....mos.....ds.

(Signed) Otto K. Leonhardt M. D.
(Coroner)
March 6, 1923. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Accident Annapolis Boulevard. March 1, 1923.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	March 8th 19.23

20-UNDERTAKER.	ADDRESS
Leo Lemibach & Son	647 N. Broadway

(Please write plainly so properly classified. Exact statement of OCCUPATION desired. See instructions on back of certificate.)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73472

CERTIFICATE OF DEATH.

D73472

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 Patapsco St (St.) (WARD) 25

2-FULL NAME John F Bindeman Jr.

(a) RESIDENCE NO. 205 Patapsco St ST., WARD Penna

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22d 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	1	10	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER John F Bindeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lucy Selby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mr John F Bindeman

(Address) 205 Patapsco St

15 MAR 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1923 to March 6, 1923

that I last saw him alive on March 5, 1923

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Scarlatina

4 (duration) 8 yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M L Fuhringer M. D.

, 19 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral, Penna	March 7 1923
20 UNDERTAKER John F Cowan & Son	ADDRESS
Chas J. Cowan	901 Hollins St

IMPORTANT—Before filling out this certificate, read carefully the instructions on back hereof. Each item of information must be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D73473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D73473

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 S. Bond. ST., 3 WARD)

2-FULL NAME Geo. C. Hinkelman

(a) RESIDENCE NO. 29 S. Bond. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mal

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 3 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo Hinkelman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Catharine Morob

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Geo. Hinkelman (Address) 29 S. Bond

15 MAR 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1923, to Mar 6, 1923, that I last saw h[illegible] alive on Mar 6, 1923 and that death occurred, on the date stated above, at 9.20 A m.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. H. Ryan M. D.

(Address) 1501 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Mar 7 1923
20 UNDERTAKER Robt S Little	ADDRESS 230 E Monument

IMPORTANT. PHYSICIANS should state name, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73474

CERTIFICATE OF DEATH.

101-01 D73474

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Women Home ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Grove

(a) RESIDENCE NO. 1400 W Lexington ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 17 yrs. — mos. (ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 9, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87		23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) — Anhurn
(State or country) —

PARENTS

10 NAME OF FATHER Lewis J. Grove

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER Louella Bevins

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Miss. Ella J. Jones
(Address) Aged Women's Home

15 Filed MAR 7 - 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 6, 1923, to Mch 6, 1923,
that I last saw h alive on Mch 6, 1923,
and that death occurred, on the date stated above, at 12 30 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J Norwood, M. D.

Mch 6/23, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet.	March 7, 1923
20 UNDERTAKER George J. Smith.	ADDRESS Fayette St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- stated EXACTLY. PHYSICIANS should state it may be properly classified. Every item of infor-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73475

REGISTERED NO.

D73475

1. PLACE OF DEATH 1114 Druid Hill Ave

CITY OF BALTIMORE: (No. Baltimore ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Annie C. Simpson

(a) RESIDENCE NO. 1114 Druid Hill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Eastern Shore Md

PARENTS

10 NAME OF FATHER: Major Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Laura Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Richard Simpson
(Address) 1114 Druid Hill Ave

15 Filed MAR 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 4, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1922. to Mar. 3, 1923.

that I last saw her alive on Mar. 3, 1923.

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Edema (Pulmonary)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Asphixia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

19 (Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Gen	3/7 1923
20 UNDERTAKER: Samuel J. Kemsley	ADDRESS 715 N Eutaw St

IMPORTANT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATIONS is very important. See Instructions on back of certificate; so that it may be properly classified.

D73476

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73476

CERTIFICATE OF DEATH.

1-PLACE OF DEATH on the corner of Smith & Penna. Ave. REGISTERED NO. C

CITY OF BALTIMORE (No. ~~1403~~ ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Commodore

(Residence in Baltimore: No. 1403 Mc Culloh St St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1885 (Year)

7-AGE, 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Richmond Co Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Commodore

(Address) 1403 Mc Culloh St

15-

MAR 7 - 1923. 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. O'Hennessy M. D. (Coroner)

March 4, 1923 (Address) 30 Fayette East

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, March 7, 1923

20-UNDERTAKER Samuel Hennessy ADDRESS 1778 Eddie

Important. See instructions on back of certificate. Please write plainly. Words must be stated EXACTLY. PHYSICIANS should state terms, so that it may be properly classified. Exact statement of OCCUPATION is very

D73477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 101-001 D73477

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1206 Edward St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonaed Murray

(Residence in Baltimore: No. 1206 Edward St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write One word.)
male	black	Single

6-DATE OF BIRTH, Oct 6/1891 1.....
(Month) (Day) (Year)

7-AGE. 31 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS:

10-NAME OF FATHER. Wm. Murray

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Margaret Pikes

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Robert Elliott

(Address) 1725 Ashland Ave.

15- Filed MAR 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar-pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Walter M. D.
(Coroner.)

3/3/23 192.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	March 7 1923

20-UNDERTAKER.	ADDRESS
Mrs Robert E Elliott	1725 Ashland Ave

See instructions on back of certificate. PHYSICIANS should properly classified. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

D73478

Clem Richardson
101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 12 WARD)

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clem Richardson

(a) RESIDENCE No. 1624 Latrobe St ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 22 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 35 Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Clem Richard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Bowman (Address) 1624 Latrobe st

15 Filed MAR 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923, to March 4, 1923, that I last saw him alive on March 3, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Cause of Exposure

Cold. (duration) 1 yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? physical Exam

(Signed) E. H. Hall, M. D.

, 19 (Address) 926 E 25 st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int-Auburn Cem	March 6 1923
20 UNDERTAKER	ADDRESS
Wm Robert A Elliott	Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73479

CERTIFICATE OF DEATH.

90 ✓

D73479
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 Hanneman ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna M. Schriefer

(a) RESIDENCE NO. 2213 Hanneman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Michael Schriefer

6 DATE OF BIRTH (month, day, and year) 3/14/1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER G. Kestler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Baxter.
(Address) 2213 Hanneman Ave

15 Filed 1923 ROBERT H. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1922, to March 6, 1923.
that I last saw he alive on March 5, 1923
and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. D. Gray, M. D.

3/7, 1923 (Address) 607 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: March 8, 1923

20 UNDERTAKER: Geo. J. Ruth ADDRESS: 1735 Eutaw ave

IMPORTANT. See instructions on back of certificates.

Form—1-10-21—M&T—1500 Bks.

D73480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D73480

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 E. Balto St. ST., 3 WARD)

2-FULL NAME Rosa Dragent

(a) RESIDENCE No. 1627 E Balto St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Dragent

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mendle Zelfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1439 E Balto St

15 Filed MAR 7 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6 1923

17 I HEREBY CERTIFY, That I attended deceased from February 27, 1923 to March 6, 1923, that I last saw her alive on March 6, 1923, and that death occurred, on the date stated above, at 12 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical finding

(Signed) M H Patterson, M. D.

3/6, 1923 (Address) 1627 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lucas Rosedale	March 7, 1923
20 UNDERTAKER	ADDRESS
Jack Levis	1429 E Balto

THION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73481

CERTIFICATE OF DEATH.

129 ✓ D73481

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 S. Woodyear St. ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Longley

(a) RESIDENCE NO. 331 S. Woodyear St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Longley

6 DATE OF BIRTH (month, day, and year) May 4th 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Catonsville
(State or country) Md.

PARENTS

10 NAME OF FATHER William Betts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Julia Peddicord

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Mary V. Hammer
(Address) 2002 Hollins St.

15 MAR 7-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5th 19 23

17 I HEREBY CERTIFY, That I attended deceased from 2/28 19 23 to 3/5/23 . 19 .

that I last saw h alive on 3/4/23 . 19 ;

and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia 5 days.
Chr. Int. Nephritis ?
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza ?
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) T. H. Wessels M. D.

3/6. 1923 (Address) 1302 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Mch 8th 1923

20 UNDERTAKER Jno B Cook

ADDRESS 602 W Baltimore

THAT it may be properly classified. PHYSICIANS should state EXACTLY. Every item of information is very important. See instructions on back of certificates. Exact statement of OCCUPATIONS on back of certificates.

D73482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D73482

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2708 O'Donnell St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Bonning

(Residence in Baltimore: No. 2708 O'Donnell St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Apr 30th (Month) (Day) 1883 (Year)

7-AGE: 39 yrs. 10 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Philipp J. Bonning

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Weis

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philipp J. Bonning

(Address) 917 So. Ann St

15. Filed MAR 7 - 1923 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. B. Horton M. D.
Coroner.
Mch 8 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western — DATE OF BURIAL: Mch 8 1923

20-UNDERTAKER: Zirkler & Zirkler — ADDRESS 1739 Eager

IMPORTANT. See instructions on back of certificate. It may be properly classified. Exact statement of OCCUPATION

Spec.—1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73483

CERTIFICATE OF DEATH.

47 D73483

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Park Ave. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Erich

(a) RESIDENCE NO. 615 Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE ~~White~~ Negro Servant

5 Single, ~~Married, Widowed, or Divorced~~, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 12, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 05-4

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Augustus F. Erich

11 BIRTHPLACE OF FATHER (city or town) Eisleben (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Baetzer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Edna Erich (Address) 615 Park Ave Baltimore

15 FILED MAR 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/20, 1922, to 3/6, 1923, that I last saw h[illegible] alive on 3/5, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast.
Metastases to Pleura

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter A Baetzer, M. D.

(Address) 900 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Co

DATE OF BURIAL 3-8-1923

20 UNDERTAKER Henry W Jenkins Sons Co

ADDRESS Orchard McCulloh

IMPORTANT. CERTIFICATE OF DEATH should be stated EXACTLY. Every item of information in plain terms, so that it may be properly classified. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73484

CERTIFICATE OF DEATH.

161-001 D73484

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cradle

(a) RESIDENCE NO. 756 George St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 20/23

7 AGE — Years — Months — Days 6 days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Cradle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Gertrude Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W.W. Gray
(Address) Johns Hopkins Hospital

15 MAR 7 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 20 , 1923 , to Feb 26 , 1923 ,

that I last saw h alive on Feb. 26 , 1923 ,

and that death occurred, on the date stated above, at 9.40 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W.W. Gray , M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS MAR 6 - 1923

Commissioner Health.

Per. Wm. E. WOODALL

THIS is very important. See Instructions on back of certificates. Every item of information should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D73485

D73485 CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Andrews

(a) RESIDENCE NO. 2241 Barclay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year) 2/27/23.

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant. old

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Johns Hopkins Hospital Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Louise Andrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland USA

14 Informant: Johns Hopkins Hospital. (Address)

15 MAR. 7-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to Feb. 28, 1923, that I last saw him alive on Feb 28, 1923, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Sign & Clinical picture.

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER: Commissioner Health, per. Wm. E. Woodall

ADDRESS MAR 6 1923

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Every item of information should be properly classified. PHYSICIANS should state EXACTLY, so that it may be

Spec.—1-10-21—M&T—1500 Blks.

16 1970 D73486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 1-001 D73486

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Goode

(a) RESIDENCE NO. 1204 Brevard St City ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Charles Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Goode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed MAR 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to March 1, 1923

that I last saw him alive on March 1, 1923,

and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) H. H. Weed, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 3/6 1923

20 UNDERTAKER (By Commissioner Health.)

ADDRESS

OTHER SIDE

IMPORTANT: Answer every item, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73487

CERTIFICATE OF DEATH.

90 D73487

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Argyle ave, ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H. Tyson

(a) RESIDENCE. No. 1312 Argyle ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sue E. Tyson

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Baltimore And

PARENTS

10 NAME OF FATHER William Tyson

11 BIRTHPLACE OF FATHER (city or town). (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah J. Brown

13 BIRTHPLACE OF MOTHER (city or town). (State or country) Va

14 Informant Wm. J. Tyson
(Address) 13 E Argyle ave

15 MAR 7 - 1923 Registrar ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1923, to Mar 4, 1923, that I last saw him alive on Mar 4, 1923, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

3-6, 1923 (Address) 120 Biscayne St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mch 8 1923
20 UNDERTAKER	ADDRESS
Samuel V. Chase & Son	400 Mosher

Item of information should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—R. P. Co.—1000 Bks.

Savarese ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73488

CERTIFICATE OF DEATH.

8 D73488

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. 11th St. ST.: N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvadore Savarese

(a) RESIDENCE. No. 18 N 11th St Highlandtown WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 27-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~none~~ 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER August Savarese

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Kate Bonitatibus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant August Savarese
(Address) 18 N 11th St

15 FILED MAR 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1923, to Mar 7, 1923, that I last saw h.. alive on Mar 7, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Malignant Pustule

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Malignant Disease

Fever (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Bacteria

(Signed) Alan B Lemmon, M. D.

3/7/23 (Address) 710 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakdawn Cemetery	3/8 1923

20 UNDERTAKER George J Ruth ADDRESS 1135 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73489

CERTIFICATE OF DEATH.

5 88 D73489

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1418 McElderry St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Johnson

(Residence in Baltimore: No. 1418 McElderry St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, Divorced. (Write the word.)
female	colored	married

6-DATE OF BIRTH. Feb 28/1887 1..... (Month) (Day) (Year)

7-AGE. 36 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country). Richmond Co. Va

PARENTS.

10-NAME OF FATHER. John Henry

11-BIRTHPLACE OF FATHER, (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Mary Thompson

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Johnson (Son)

(Address) 1418 McElderry

Filed MAR 7 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 4/23 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

ProbablyEndocarditis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) J S H Fuller M. D. (Coroner.)

EJRJWE 3/4/23 192.. (Address) 503E. NOrth Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
asBury cemetery	march 7 1923

20-UNDERTAKER. Edward Bryan ADDRESS 1631 orleans st

Instructions: Must be filled EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION may be necessary. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 49 D73490

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 W. Lexington St. 20 WARD)

2-FULL NAME George Edmund-

(a) RESIDENCE. NO. Bozman Md- ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 3 weeks How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Edmund

6 DATE OF BIRTH (month, day, and year) April 20 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81.	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer- ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond. Va-

PARENTS

10 NAME OF FATHER Robert Edmund-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Sarah Pettes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant Mae Edmund Bridges (Address) 2109 W. Lexington St-

15 Filed MAR 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1922, to March 7, 1923, that I last saw him alive on March 6, 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Orbit & Cervical)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bozman - Talbot Co

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopical

(Signed) John Houff, M. D.

19 (Address) 1843 20 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Mt Olivet Cemetery Mar 8 1923

20 UNDERTAKER ADDRESS

Wilbur W. Chivers, 1018 Edmondson Ave

FOR is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73491 CERTIFICATE OF DEATH. 128 D73491

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Nolan

(a) RESIDENCE NO. 615 N. Calvert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Anthony Nolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant unicipal Hospital Records. (Address)

15 MAR 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to March 3, 1923, that I last saw him alive on March 3, 1923, and that death occurred, on the date stated above, at 12:35 P.M.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute alcoholism

(duration) yrs. mos 30 ds.

18 Where was disease contracted if not at place of death? Said to

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Brune, M. D.

3-6-, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health.

ADDRESS MAR 7 - 1923

TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D73492

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D73492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3806 Woodbine Ave ST., 28 WARD)

2-FULL NAME Clarissa Frances Corwal.

(a) RESIDENCE NO. 3806 Woodbine Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, '22.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
89)	89	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bed paralyzed for 16 yrs. poo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Gloucester Co., Va.

PARENTS

10 NAME OF FATHER Milton Mason.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Elizabeth Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mrs. Clarence Jarvis (Address) 3806 Woodbine Ave.

15 Filed 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-6- 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 6, 1923. to Mar. 6, 1923.

that I last saw h[illegible] alive on Mar. 6, 1923.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis of Senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A Meredith Sorell M. D.

. 19 (Address) 370 Liberty Hgts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park

DATE OF BURIAL MAR 8 1923

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

IMPORTANT is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73493

D73493

CERTIFICATE OF DEATH.

X 183

REGISTERED NO. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard-Green ST., 4 WARD)

2-FULL NAME Earl Nichols Mathews

(a) RESIDENCE NO. Elkridge Ind ST., ... WARD Elkridge Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Mathews

6 DATE OF BIRTH (month, day, and year) ? ? 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Elkridge Ind

PARENTS

10 NAME OF FATHER Wm. Mathews

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Ida Cager

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant George Thomas
(Address) Elkridge Ind

15 Robert F. Harrison, 7-1923, 19 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1923, to Mar 7, 1923,

that I last saw him alive on Mar 7, 1923,

and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Adhesions following operating
Gun Shot of abdomen. May 1922.
Intestinal obstruction
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gangrenous intestine
(duration) ..... yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Mar 6 1923

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) J. H. Brunstick, M. D.

Mar 7 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md.	3-7 1923
20 UNDERTAKER E B Hall	ADDRESS 115 E Mead St

TION is very important. See instructions on b... on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 D73494

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 W. Franklin ST., 4 WARD)

2-FULL NAME Marie Louise Kelly

(a) RESIDENCE NO. 211 West Franklin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph M. Kelly

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	0)	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Edward Fay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marie Louise-----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edw. B. Kelly

(Address) 211 West Franklin St.

15 Filed 1923 . 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. , 1922 , to Mar. 6 , 1923 .

that I last saw her alive on Mar. 3 , 1923 ,

and that death occurred, on the date stated above, at 8.00 A m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

sudden death. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Francis X. Kearney, M. D.

. 19 (Address) 16 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/ 8 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified., should be stated EXACTLY. PHYSICIAN'S

Spec.—1 10-21—M&T—1500 Bks.

D73495

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73495

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Altoona Ave. Hamilton ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Strodthoff

(a) RESIDENCE NO. Altoona Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Strodthoff

6 DATE OF BIRTH (month, day, and year) May 4, 1849.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	73	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cath. Watters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Albert R. Zimmerman

(Address) Altoona Ave. Hamilton

15 7-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1923, to March 5, 1923, that I last saw her alive on March 4, 1923 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Rheumatoid Arthritis

(duration) No of yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb W. Bluey, M. D.

March 6 1923 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Mch. 7. 1923
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway,

DEATH is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73496

CERTIFICATE OF DEATH.

101-001

D73496

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 S. Clarens. ST. 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Read

(Residence in Baltimore: No. 824 S. Clarens. St.; unknown yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... unknown, 1883
(Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Asst. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Steamship

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Pritchett

(Address) 1925 Jefferson st.

15-

Filed ..... Dr. Robert P. Harrison,

1923 Burial Permit Clerk,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 5 23., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 2 23 191, to Mar 5 23 191, that I saw h.. alive on Mar 5 23 191 and that death occurred, on the date stated above, at 5-30 p. m.

The CAUSE OF DEATH* was as follows:

..... Pleuro-Pneumonia.

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Thomas Clinton M. D.

Mch. 6 23 191 (Address) 933 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem. DATE OF BURIAL, Mch. 8..., 1923.

20-UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

INSTRUCTIONS: PHYSICIANS should state properly classified. Exact statement of OCCUPATION is ... See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D73497

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73497

CERTIFICATE OF DEATH.

74-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) #2114-Bolton-St. ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Louise Hinks

(a) RESIDENCE NO. #2114-Bolton-St. ST., 13 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? 72 yrs. 10 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) April-24-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Hinks

11 BIRTHPLACE OF FATHER (city or town) Ellicott City
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Nixdorff

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country) Maryland

14 Informant Mr. Geo. M. Hinks, (brother)
(Address) 2114-Bolton-St., City.

15 7-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 8th, 1923, to March 6th, 1923, that I last saw h[illegible] alive on March 5th, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:
Cerebral thrombosis

(duration) ✓ yrs. ✓ mos 27 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, with Uremia
Pneumonia (duration) 16 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Warfield M. D.

3-7, 1923 (Address) 1515 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREENMOUNT CEMETERY — DATE OF BURIAL: Mar-7-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73498

CERTIFICATE OF DEATH.

11-00 D73498

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1607 N. Caroline (St.:) 8 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Ashcom Collison

(a) RESIDENCE. No. 1607 N. Caroline St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ (or) WIFE of Wm. F. Collison

6 DATE OF BIRTH (month, day, and year) Dec 19-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: John L. Ashcom

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Robert Ann Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Leonardtown Md.

14 Informant: A. Collison (Address): 1607 N. Caroline St.

15 Filed ....., 19.... Robert P. Harrison, Registrar

1923

Burial Permit Clerk:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Mar 5, 1923, that I last saw h.. alive on Mar 5, 1923 and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Encephalitis

000

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

3-7-1923 (Address) 120 Fairmount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	3/8/23

20 UNDERTAKER: H E Stephen ADDRESS: 4 ret St. Broadway

IMPORTANT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state plainly and in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73499

CERTIFICATE OF DEATH.

117 D73499

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Bloomfield

(a) RESIDENCE NO. 614 N. Arlington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1" 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
36	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tea Room Proprieter

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles M. Bloomfield

11 BIRTHPLACE OF FATHER (city or town) St. Louis
(State or country) Mo.

12 MAIDEN NAME OF MOTHER Mary C. Wagner

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.
(State or country) Md.

14 Informant Mrs. Margaret M. Birchall
(Address) 614 N. Arlington Ave.

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 7" 1923

17

I HEREBY CERTIFY, That I attended deceased from March 4th, 1923, to March 7th, 1923.

that I last saw h[illegible] alive on Mar. 7th, 1923

and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic appendicitis
Ptosis of colon.
Mitral stenosis.

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary oedema
Acute Dilatation (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes. Date of 3/5/23.

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examination

(Signed) J. J. Bamford, M. D.

3/7, 1923 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	March 9, 1923
20 UNDERTAKER	ADDRESS
Joseph L. B. Cook	1003 N. Bello St

TION is very important. See instructions on back of certificates. Every item of information is required by law to be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-

Spec—12-23-21—E.B.R.S.—400 Eks.

D73500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73500

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Russel Smith

(a) Residence No. Newtown Bucks Co. Pa St., Ward Newtown Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 21 1894

7-AGE, 28 yrs. 7 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steward.

(b) General nature of industry, business, or establishment in which employed (or employer) 179

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Moses Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna.

12-MAIDEN NAME OF MOTHER, Ella Macdonell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14- (Informant) Hospital Record

(Address)

15- 1923 Robert F. Harrison, 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 7 '23

17- I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1923, to Mar. 7 1923

that I last saw h alive on Mar. 7 1923,

and that death occurred, on the date stated above, at 11 25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis. Acute Hematinides

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs Collapse Failure (Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Gallows Confinement to Prison

Did an operation precede death? Yes Date of 2-8-23

Was there an autopsy? NO

What test confirmed diagnosis? Sym + Per. Findings

(Signed) D. J. Sexton M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Trenton N. J.	March 8. 1923
20-UNDERTAKER.	ADDRESS
Chas. G. Black	742 W. Fayette ave

Instructions on back of certificates.

Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE OF DEATH properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D73501

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73501

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 429 Euclid ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Carey

(a) RESIDENCE NO. 4219 Euclid ST., 70 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Carey

6 DATE OF BIRTH (month, day, and year) — — 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.
(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Pierpoint

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Abalina Kennedy

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. A. Miller
(Address) 104 Augusta

15 1923 Robert P. Harrison, 17 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 6, 1923, that I last saw h[illegible] alive on March 6, 1923, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No.

Was there an autopsy?

What test confirmed diagnosis? Physical findings

(Signed) W. A. Miller, M. D.

3/6, 1923 (Address) Irvington.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodstock Md.

DATE OF BURIAL 3/9 1923

20 UNDERTAKER John J. Fahy & Son

ADDRESS 1518 Light St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73502

CERTIFICATE OF DEATH.

X 31

REGISTERED NO. D73502

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 14 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Epps

(a) RESIDENCE NO. 2122 Druid Hill avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State) Virginia

Length of residence in city or town where death occurred Unknown 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cleveland Epps Not given.

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Austin Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Edith Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 MAR 8-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1923, to March 5, 1923, that I last saw her alive on March 5, 1923, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) Francis L. Delafield, M. D.

3-5-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	3 8 1923
20 UNDERTAKER Samuel Kennedy	ADDRESS 518 Madison

TION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73503

CERTIFICATE OF DEATH.

31 D73503

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56, REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MCHENRY, BALTO., MD. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ELLIS, Richard

(a) RESIDENCE NO. 309 Myrtle Ave., Balto., Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) --

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
27	XX	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer): --

(c) Name of employer: --

086

9 BIRTHPLACE (city or town) -- (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) -- (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) -- (State or country) Unknown

14 Informant: Hospital Records (Address) Fort McHenry, Baltimore, Md.

15 MAR 8 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from February 26, 1923, to March 6, 1923, that I last saw h imalive on March 6, 1923, and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary tuberculosis, Far Advanced & Active.

(duration) 5 yrs. mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Physical findings- X-ray - tubercular bacilli in sputum.

(Signed) [redacted], Surgeon (R), M. D.

3/7/1923 (Address) Fort McHenry, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Natural Bridge Stat. Va — DATE OF BURIAL: 3/8. 1923

UNDERTAKER: J. Lennon & Bro — ADDRESS: 1127 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73504

CERTIFICATE OF DEATH.

44 D73504

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Lakeview ave ST., 13 WARD)

2-FULL NAME Max S. Segall

(a) RESIDENCE No. 2405 Lakeview Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 23 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE — Years: 49 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Israel Segall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mollie Polansky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs Sarah Segall

(Address) 2405 Lakeview Ave

15 Filed MAR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1922, to March 7, 1923, that I last saw him alive on March 7, 1923, and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) ... yrs. 8 mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of Oct 19 22

Was there an autopsy? No

What test confirmed diagnosis? Inspection

(Signed) Joseph Eichner, M. D.

, 19 (Address) 516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cemet

DATE OF BURIAL: 3/8 1923

20 UNDERTAKER: A. Levinson & Bro

ADDRESS 11 LT E Balto St

THE INFORMATION is very important. See instructions on back of certificates. Every item of information must be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

D73505

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73505

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hosp

CITY OF BALTIMORE: (No. Monument & Rutland St. 5 WARD)

REGISTERED NO. 118-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Louis Weitzman

(a) RESIDENCE NO. 421 N Exeter St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? 32 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rev

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sam Weitzman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Sarah Weitzman

(Address) 421 N Exeter St

15 Filed MAR 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1923

17

I HEREBY CERTIFY, That I attended deceased from March 3rd, 1923, to March 7, 1923.

that I last saw h[illegible] alive on March 7th, 1923.

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Carditis Dilatation

over

(duration) yrs. mos 1 hrs.

CONTRIBUTORY (Secondary) Terminal Bronchio Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 3/3/23

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms Lastly

(Signed) Adler Goudheimer M. D.

3/7, 1923 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Henry Ave	3/8 1923
20 UNDERTAKER	ADDRESS 1127 E Baltimore St
L. Levinson & Bro	

INFORMATION is very important. See instructions on back of certificates. Every item of information should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATIONS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73506

CERTIFICATE OF DEATH.

51 D73506

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bali Weinstein

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Wife of Mr Weinstein.

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	64	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) (?) Russia.

PARENTS

10 NAME OF FATHER Jacob Bayuk

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Russia

12 MAIDEN NAME OF MOTHER Annie (unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Russia.

14 Informant (Address) Records of Mt Hope Retreat Supposed to be Md

15 Filed Mar 8 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923, to March 7, 1923, that I last saw h er alive on March 7, 1923, and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

Inflamatory Rheumatism with Myocarditis

abt (duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Mania Depns. Psychosis - Renal (duration) (?) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Road	March 9 1923

20 UNDERTAKER Jack Levin ADDRESS 1432 E. Oliver

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION should state in plain terms, so that it may be properly classified. PHYSICIANS should state EXACTLY. Every item of information must be stated

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73507

REGISTERED NO. 73 D73507

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 E. Madison ST., 11 WARD)

2.-FULL NAME Joseph Chamberlaine

(a) RESIDENCE NO. 12 E Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna R. R. Chamberlain

6 DATE OF BIRTH (month, day, and year) 2-25-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Easton (State or country) Md

PARENTS

10 NAME OF FATHER Joseph E. McChamberlain

11 BIRTHPLACE OF FATHER (city or town) Easton (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth J. Hayward

13 BIRTHPLACE OF MOTHER (city or town) Easton (State or country) Md

14 Informant Joseph E. McChamberlain (Address) 12 E Madison St

15 Filed MAR 8 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/24, 1923, to 3/7, 1923.

that I last saw him alive on 3/7, 1923,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. H. Chamberlain M. D.

3/8 1923 (Address) 1006 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md.

DATE OF BURIAL 3-8 1923

20 UNDERTAKER Henry W. Erkin Sons Co

ADDRESS Mitchell & Orchard

IMPORTANT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D73508

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D73508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Homewood Hospital REGISTERED No. C.....

CITY OF BALTIMORE: (No. Homewood Hospital WARD)

2-FULL NAME Jason W. Stockbridge

(Residence in Baltimore: No. 544 N Fulton Avenue St.; ....yrs. ....mos. ....ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and add ward No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July 10, 1923 (Month) (Day) 1 (Year)

7-AGE, 43 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Newspaper Editor.
(b) General nature of industry, business, or establishment in which employed (or employer): Literary

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Sylvester L.

11-BIRTHPLACE OF FATHER (State or Country), Massachusetts.

12-MAIDEN NAME OF MOTHER Mary A. Cobb.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife: Cora B. Stockbridge

(Address) 544 N. Fulton Avenue.

15- Filed MAR 8 - 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 17 1923 to Mar 7 1923, that I saw h[illegible] alive on Mar 7 1923, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) ....yrs. ....mos. 17 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ....yrs. ....mos. ....ds.

(Signed) Louis A. Fetherston M. D.

(Address) 2724 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ....yrs. ....mos. 1 ds. In the State 22 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 544 N Fulton Ave

Former or usual residence 544 N Fulton Ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park,	March 11, 1923, 191...

20-UNDERTAKER John O. Mitchell 1201 W. ADDRESS Fayette St.

Use instructions on back of certificate. It may be properly classified. Exact statement of OCCUPATION is very

Remarks Lobar

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73509

CERTIFICATE OF DEATH.

32 D73509

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Cor Lombard & Greene ST. 17 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hensel Cockey

(a) RESIDENCE NO. 2503 N. Calvert ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Cockey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER May Poulson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.

(Address)

15 Filed MAR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1923, to March 7, 1923

that I last saw her alive on March 7, 1923,

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) Possibly 2 wks. ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) Sudden mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No, Gross Examination

What test confirmed diagnosis? Gross Appearance

(Signed) Mercy Hospital M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Hope Cem. DATE OF BURIAL 3/9/23

20 UNDERTAKER Wm C Whitehill ADDRESS 1201 W Fayette

TION is very important. See instructions on back of certificates.

should be stated EXACTLY. PHYSICIANS should state may be properly classified. Exact statement of OCCUPA-

D73510 HEALTH DEPARTMENT—CITY OF BALTIMORE 197 D73510

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. In front of 1706 Gough St. Street 3 Ward)

2-FULL NAME. James Baker

(Residence in Baltimore: No. 218 So. Dallas St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) (Year)

7-AGE. About 36 yrs. # mos. # ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15-

Filed MAR 8 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2nd (Month) (Day) 192..3 (Year)

I HEREBY CERTIFY, That I held an Autopsy of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Lung
Pat ordered
Supposed to have been shot
by Harry Green

CONTRIBUTORY (Secondary or Antecedent) (Duration) yrs. mos. ds.

(Signed) Geo. P. Horton M. D. (Coroner.)

March 5th 192 3 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, March 8 1923

20-UNDERTAKER, Wm Robert A Ellis ADDRESS 1725 Oakland Av

If very important. See instructions on back of certificate. Exact statement of OCCUPATION should be stated EXACTLY, PHYSICIANS should use plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73511

CERTIFICATE OF DEATH.

101-001

D73511

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2419 Stockton ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mazie Hall

(a) RESIDENCE NO. 2419 Stockton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mose Hall. dec

6 DATE OF BIRTH (month, day, and year) Dec 28 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Henry Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Ada Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mrs Ada Young

(Address) 2419 Stockton

15 Filed MAR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-3- , 1923, to 3-7- , 1923.

that I last saw h[illegible] alive on 3-7- , 1923.

and that death occurred, on the date stated above, at 1130 P.M.

The CAUSE OF DEATH* was as follows:

Lob Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs mos. 5 ds.

18 Where was disease contracted if not at place of death? 2419 Stockton

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm R. Boykin M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MtLucas	Mar 9 1923
20 UNDERTAKER	ADDRESS
Clarence E. Umpstead	Roslyn

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar

D73512 HEALTH DEPARTMENT—CITY OF BALTIMORE 99-002 D73512

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1249 E. Lexington St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anton Rich

(Residence in Baltimore: No. 1249 E. Lexington St.; yrs., 83 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. April 5/1839 (Month) (Day) (Year)

7-AGE. 83 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 0/5

9-BIRTHPLACE. (State or Country). Ellicott City Md.

PARENTS.

10-NAME OF FATHER. John Rich

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Rich

(Address) Reistertown Md.

15- MAR 8 - 1923 ROBERT R. KRAUTER, Filed ..... 192.... Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 6/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis (Primary)

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) J. S. H. Tull M. D.
(Coroner.)

3/7/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenmount	March 8 1923

20-UNDERTAKER. H. M. Cornell — ADDRESS 32 S. Broadway.

It is very important. See instructions on back of certificate. Every item should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73513

CERTIFICATE OF DEATH.

129 D73513

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Light St. ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Henry Benedict

(a) RESIDENCE NO. 720 Light St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of)

6 DATE OF BIRTH (month, day, and year) Oct 23, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint Broker

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jesse Benedict

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Keith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas. F. Benedict

(Address) 715 Light St.

15 MAR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1923

17

I HEREBY CERTIFY, That I attended deceased from Feby 8, 1923, to Mar 7, 1923,

that I last saw alive on Mar 5, 1923,

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Hyp Kidney (Interstitial)

(duration) yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) W. S. Smith, M. D.

, 19 (Address) 119 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	3/9/23
20 UNDERTAKER	ADDRESS
J. E. Denny	715 Light St.

IMPORTANT—CERTIFICATE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73514

CERTIFICATE OF DEATH.

144 ✓ D73514

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S Hallas ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Anthony Johnson

(Residence in Baltimore: No. 105 S Hallas St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	Married

6-DATE OF BIRTH, Dec 22, 1896
(Month) (Day) (Year)

7-AGE, 26 yrs. 3 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Lloyd Anthony

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mollie Chambers

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mollie Anthony Miller

(Address) 105 S Hallas

15-

Filed MAR 8 1923 ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 5 1923, to March 5 1923, that I saw her alive on March 5 1923, and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:

Post-partem Hemmorrhage

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Pregnancy

(Duration) ....yrs. 8 mos. ....ds.

(Signed) [illegible] M. D.

3/7, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Lawn	3/9/1923
20-UNDERTAKER	ADDRESS
Thos White	113 S Wolfe St

Spec.—8-24-14—M. & T.—2000 Bks. HEALTH DEPARTMENT—CITY OF BALTIMORE. CERTIFICATE OF DEATH. ...must be stated EXACTLY. PHYSICIANS should state ...that it may be properly classified. Exact statement of OCCUPATION is very ...portant. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73515 HEALTH DEPARTMENT—CITY OF BALTIMORE D73515

CERTIFICATE OF DEATH. X 49

1-PLACE OF DEATH Miss Mair's private hospital Registered No. 2327

City of BALTIMORE: (No. 723 St. Paul St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lucy Hart Wilson

(a) Residence No. 502 Stanley Ave., Clarksburg, W. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of H. T. Wilson

6-DATE OF BIRTH (month, day and year) Sept. 9, 1862

7-AGE. 60 yrs. 5 mos. 26 ds. If LESS than 1 day, 0 hrs. or 0 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Clarksburg W. Va

PARENTS.

10-NAME OF FATHER. Ira Hart

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Clarksburg W. Va

12-MAIDEN NAME OF MOTHER. Mary Neally

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Clarksburg W. Va

11- (Informant). J. K. Hoge, records

(Address) Da Price Clarksburg W. Va

15- Filed MAR 8 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-7-23

17- I HEREBY CERTIFY, That I attended deceased from Feb. 17 1923 to Mar. 7 1923

that I last saw her alive on Mar. 7 1923

and that death occurred, on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:

Pancreatic neoplasm, probably malignant

about
(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Clarksburg W. Va

Did an operation precede death? Yes Date of 7-25-21

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Richard Dresser M. D.

Mar 7. 1923 (Address) 723 St. Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. CLARKSBURG

DATE OF BURIAL. 3-10- 1923

20-UNDERTAKER. Robert Brooke Colson

ADDRESS Callan & Holland

Instructions on back of certificates. Every item of information must be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See

D73516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D73516

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1803 Mc Culloh St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence E. Newsome

(Residence in Baltimore: No. 1803 Mc. Culloh St. St.; yrs. 7 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	colored	single

6-DATE OF BIRTH. July 23 1915
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, David Newsome

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Bessie L. Walden

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie L. Newsome

(Address) 1803 Mc Culloh St

15- FILED MAR 8 - 1923 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) none

(Duration) 1 yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

March 7 1923 (Address) 200 E. Lanvale St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem.	3/8/23

20-UNDERTAKER Jas. Easter ADDRESS 916 Penna Ave

18 very important. See instructions on back of certificate. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should use plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D73517 HEALTH DEPARTMENT—CITY OF BALTIMORE D73517

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hosp'l ST., 4 WARD)

2-FULL NAME William Johnson

(a) RESIDENCE No. 104 6. Mulberry st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Johnson

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Cecil Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 7, 1923, that I last saw him alive on March 7, 1923, and that death occurred, on the date stated above, at 5.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum,

(Signed) Francis L. Dalogliacca, M. D.

3-7-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetary	March 10 1923
20 UNDERTAKER	ADDRESS
Joseph T.H. Rochester	1113 Jefferson st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state AGE should be computed.

HEALTH DEPARTMENT—CITY OF BALTIMORE

002

D73518

CERTIFICATE OF DEATH.

75 - D73518

D73518

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Brunt ST.: 14 WARD)

REGISTERED No. C.....

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Russell Custis

(Residence in Baltimore: No. 2023 Brunt St. Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Married

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 38 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Josi Custis

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Sarah Milton

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ezell Custis

(Address) 2023 Brunt St.

15- MAR 8 - 1923 ROBERT R. KRAUTER,

Filed ....., 191..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6, 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 4 1923, to March 6 1923, that I saw h alive on March 6 1923 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Paralysis (Right side)
Hassitz Quad Paresis
Uremia
..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Coleman M. D.

Mar. 8, 1923. (Address) 2132 McCulloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, W. Lafayette

DATE OF BURIAL, 3/9, 1923

20-UNDERTAKER John T. Tracey

ADDRESS 1027 Brunt

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. PHYSICIANS should state EXACTLY, so that it may be

Remarks No Syphilis or Gonorrhoea

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *...obar pneumonia; Broncho pneumonia* ("Pneu...nia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

519 HEAL... DEPARTMENT—CITY OF BALTIMORE D73519

CERTIFICATE OF DEATH. 12 188-603

Registered No. C.....

PLACE OF DEATH

of BALTIMORE: (St. Joseph's Hospiyal ..... St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto L. Meissner ..... St.; yrs. 35 mos. ..... ds.)

dence in Baltimore: No. 414 E. 31st. St. .....

PERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-Single, Married, Widowed, Divorced (Write the word.)
male	white	married

E OF BIRTH. August 5, 1868 (Month) (Day) 1..... (Year)

	If LESS than 1 day,
54 yrs. 7 mos. 1 ds.	....hrs. or.....min.?

UPATION:
Trade, professiou, or particular kind of work ..... Retired U.S.Navy
General nature of industry, business, or establishment in which employed (or employer) .....

THPLACE, te or Country). Germany

10-NAME OF FATHER. Gustav Meissner

9-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Meissner

(Address) 414 E. 31st. St.

AR 8-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by automobile- auto driven by unknown- stolen car.
Hemorrhage within cranial cavity-
contusion of left leg. (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Patton M. D.
(Coroner.)

3/8/23 192.... (Address 508 3. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	3/8 1923

20-UNDERTAKER. Geo J Ruth ADDRESS 1735 Harford Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73520

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 Patterson Park Ave ST., WARD)

2-FULL NAME Anna Mariah Hardester

(a) RESIDENCE No. 224 Patterson Park Ave ST., WARD.....
(Usual place of abode)
Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christopher C. Hardester

6 DATE OF BIRTH (month, day, and year): Sept 24 1850

7 AGE — Years: 72 — Months: 5 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Robt. Mitchell.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Mr. David Hardester
(Address) 224 S. Patterson Park Ave

15 MAR 8 - 1923 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1923, to March 6th, 1923, that I last saw her alive on March 3rd, 1923, and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
Intestinal nephritis.
Paralysis.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Dropsy
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Wm. Carl White, M. D.

19 (Address) 1201 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pt Olivet Cem — DATE OF BURIAL: May 1923

20 UNDERTAKER: Geo M. Fuhrman Son — ADDRESS: 811 N Wolfe

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No further history

~~No syphilis~~

No haemorrhage

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73521

CERTIFICATE OF DEATH.

74-001 D73521

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 141 N. Chapel ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Charvat

(a) RESIDENCE. NO. 141 N. Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Charvat

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 72; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Jos. Kruby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Mc Verra

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): Mary Sima 141 N. Chapel St

15 FEB 10 19 MAR 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1922 to Mar 8 1923 that I last saw h alive on Mar 7 1923 and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): cerebral hemorrhage

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Horan, M. D.

19 (Address) 26 S. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Mar 12 1923

20 UNDERTAKER: Ernest Gretsch — ADDRESS: 1906 Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73522

CERTIFICATE OF DEATH.

66

D73522

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 324 S Bmaelwood St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W Jory Jr

(Residence in Baltimore: No. 324 S Bmaelwood St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Nov (Month) 8 (Day) 1886 (Year)

7-AGE. 36 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer): Steam RR Co

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Geo W Jory

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Mary Cripple

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Jory Sr

(Address) 160 N Johnson St

15- Filed MAR 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 6 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Contusion of Chest

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Hamilton M. D. (Coroner.)

Mar 8 1923 (Address) 701 E Clark St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	3-8 1923

20-UNDERTAKER.	ADDRESS
Robt Brooks & Son	Calhoun Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73523

CERTIFICATE OF DEATH.

101-001

D73523

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 Argyle Ave ST. 17 WARD)

2-FULL NAME Alverta Harbert

(a) RESIDENCE No. 938 Argyle Ave ST. 17 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-8-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Cook 121

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER Elijah Harbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Maggie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md

14 Informant Sarah Harbert
(Address) 938 Argyle ave

15 Filed MAR 8 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1923. to Mar 6, 1923.

that I last saw her alive on Mar 6, 1923

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Bilat Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J D McRae, M. D.

(Address) 1126 Druid Hill Ave

3/7 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 3-9 1923

20 UNDERTAKER Jno. H. Toadvine

ADDRESS 1142 Hull St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D73524

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 Tyson ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie McGregan

(a) RESIDENCE. NO. 429 Tyson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1870

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): 821

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Samuel Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Sarah Allsup

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Agnus Morgan 429 Tyson St

15 Filed MAR 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to March 6, 1923, that I last saw h-- alive on March 6, 1923 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: Paralysis Cerebral Hemorrhage

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) As Above

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Gordon, M. D.

(Address) 412 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. — DATE OF BURIAL: 3/9 1923

20 UNDERTAKER: John H. Goudurn — ADDRESS: 1027 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

D73525

HEALTH DEPARTMENT—CITY OF BALTIMORE

25-002 D73525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 873 Hoffman ST., 17 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Chase

(a) RESIDENCE NO. 828 Hoffman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Chase

6 DATE OF BIRTH (month, day, and year) 1/25/1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer) Public 021

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ida Walker
(Address) 1316 Myrtle Ave.

15 Filed MAR 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 23

17 I HEREBY CERTIFY, That I attended deceased from July 25 1921 to Mch. 6th 1923, that I last saw h— alive on Mch. 6th 1923, and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Progressive Paralysis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Changes (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

3-6 1923 (Address) 924 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 3-9 1923

20 UNDERTAKER Jno. H. Toadvine — ADDRESS 142 Ostend St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—3500 Blks.

D73526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73526

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 W. Barre ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Clarence Brown

(a) RESIDENCE NO. 606 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Brown .

6 DATE OF BIRTH (month, day, and year) September 29, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur (truck)

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Grocers 086

(c) Name of employer John Shoenewolfe Co. Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Hezekiah Brown

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary M.Queen.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Md.

14 Informant Hezekiah Brown, (Address) 606 W. Barre Street

15 Filed MAR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from December 1 1922, to March 5, 1923.

that I last saw him alive on March 5, 1923,

and that death occurred, on the date stated above, at 4.15 Pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? NO

What test confirmed diagnosis? Sputum tests, etc.

(Signed) D. F. Carroll, M. D.

3/5, 1923 (Address) 140 W. Hill Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	3-9 1923
20 UNDERTAKER Jno. H. Loadenn	ADDRESS 1417 Wilkens Ave

Spec. 1-10-21 M&T 1500 Blks.

D73527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Calverton Rd St., 20th WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vanier Carolyn Sherry

(a) RESIDENCE No. 118 Calverton Rd WARD 20th

(Usual place of abode)

Length of residence in city or town where death occurred 2 Mos. yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 7. 23

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Wilbur Sherry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Lillian Vanier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant (Address) Mrs Wilbur Sherry 118 Calverton Rd

15 Filed MAR 8 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 8, 1923, that I last saw her alive on March 7, 1923, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Premature Delivery at 5th Month

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones, M. D.

3-8, 1923 (Address) 222 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: March 9 23

20 UNDERTAKER: F. B. Wagner — ADDRESS: 2236 Eutaw

MARGIN RESERVED FOR BINDING

NOTICE TO PHYSICIANS AND UNDERTAKERS.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73528

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S East ave. ST., WARD)

2-FULL NAME Ernestine Matthias

(a) RESIDENCE NO. 218 S East ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or .... min
	24	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Fred. Matthias

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Mumford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jersey Nolan (Address) 202 E Barney St

15 Robert F. Harrison, Registrar

MAR 8 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923 to Mar 7, 1923

that I last saw h alive on Mar 6, 1923

and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis?

(Signed) R. H. Plummer Campbell M. D.

(Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL March 10, 1923

20 UNDERTAKER John Ulrich

ADDRESS 200 Orleans

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73529

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 S: I2 th St ST., 76 WARD)

2-FULL NAME Mary E: Hoffert

(a) RESIDENCE No. 505 S: I2 th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F: Hoffert

6 DATE OF BIRTH (month, day, and year): Oct 4th I855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George Setz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Rolliker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John F: Hoffert 505 S: I2 th St

15 MAR 8-1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6 1923

17 I HEREBY CERTIFY, That I attended deceased from January 6 1923 to March 6th 1923, that I last saw her alive on March 6th 1923, and that death occurred, on the date stated above, at 1208 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency (Death)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph J Jurden, M. D.

(Address) 32 19 Pleasant Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery

DATE OF BURIAL: Mar 9 1923

20 UNDERTAKER: John Zellich

ADDRESS: 200 E Orleans

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73530

CERTIFICATE OF DEATH.

101 D73530

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Habersham Place ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Carrico

(a) RESIDENCE No. 1635 Habersham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced; (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): March 18, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	1	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Montrose Carrico

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Ruth Maslin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Montrose Carrico

(Address) 1635 Habersham Place

15 Filed MAR 8 1923, 19 ....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 27th, 1923, to March 7th, 1923,

that I last saw h[illegible] alive on March 7th, 1923,

and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical Exam

(Signed) Guy Thompson M. D.

3/8/1923 (Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: March 9 1923

20 UNDERTAKER: Funkler & Finkler — ADDRESS: 1739 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73531

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 E. Eager ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E. Bertermann

(a) RESIDENCE NO. 1816 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank E. Bertermann

6 DATE OF BIRTH (month, day, and year): Feb. 6, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Samuel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant (Address): F. E. Bertermann Sr 1816 E. Eager

15 Filed ... 19 ... Registrar: Robert P. Harrison

MAR 8 - 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 10, 1923, to Mar 8, 1923, that I last saw h alive on Mar 7, 1923, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W White Jr M. D.

3/8, 1923 (Address) 2800 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: Mar 12 1923

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS: 1739 Eager

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73532

CERTIFICATE OF DEATH.

100-001 D73532

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Schneider

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wilford Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Nettaman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address)

15 Filed MAR 6-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 5, 1923, that I last saw him alive on March 1, 1923, and that death occurred, on the date stated above, at 2:05 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Clinical

(Signed) M. D.

3-5-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery DATE OF BURIAL 3/8- 1923

20 UNDERTAKER Mrs. M. Fink ADDRESS 1737 W. Pratt St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73533

CERTIFICATE OF DEATH.

107-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Rachel Coleman Buckner

(Residence in Baltimore: No. 1919 Henneman Ave. St.) (2 yrs., 3 mos., [illegible] ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	single

6-DATE OF BIRTH. March 3/21 ..... 1..... (Month) (Day) (Year)

7-AGE. 2 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Melson Buckner

11-BIRTHPLACE OF FATHER, (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Ethel Little Coleman

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Buckner

(Address) 1919 Henneman Ave

15- Filed ..... 192 Robert P. Harrison, Registrar.

1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 6/23 ....., 192..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Interstitial Pneumonia (Primary)

(Autopsy at Hospital)

(Duration) ..... yrs. ..... mos. 3 ...ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Cullen M. D. (Coroner.)

3/8/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel cemetery	March 8. 1923
20-UNDERTAKER. Edward Bryan	ADDRESS 1631 Orleans st

is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D73534

D73534

CERTIFICATE OF DEATH.

78

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Hazel

(a) RESIDENCE. No. Mt Hope Retreat ST. 28th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Hazel

6 DATE OF BIRTH (month, day, and year) ? ? ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elder Krauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Germany

12 MAIDEN NAME OF MOTHER Annie Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Germany

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md.

15 Filed MAR 8 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 4- 1919, 19, to March 7th, 1923, that I last saw h[er] alive on March 7th, 1923, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Epilepsy - (Spasm)

abt (duration) 6 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Epileptic Psychosis

abt (duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

March 7th, 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	3/10 '23
20 UNDERTAKER Franklin H Saltz	ADDRESS 709 W 33rd

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73535

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., ... WARD)

2-FULL NAME Henry F Daniels

(a) RESIDENCE NO. 3545 York Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or ~~WIFE~~ of) Bonnie B Daniel

6 DATE OF BIRTH (month, day, and year) Oct 7 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	46 Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

045

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Ingram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Bonnie B. Daniel

(Address) 3545 Old York Rd

15 Filed ..... 19..... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17 I HEREBY CERTIFY, That I attended deceased from February 23, 1923, to March 7, 1923, that I last saw him alive on March 7, 1923, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Asthma

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Chem.

(Signed) James Hubert Wilson M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount End. Va — DATE OF BURIAL: Mar 9 1923

20 UNDERTAKER: Wm Leo[illegible] — ADDRESS: 50[illegible] E Monument

MAR 8 1923

Burial Permit Clerk.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73536

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2721 Parkwood Ave ST., 13 WARD)

2-FULL NAME Joseph Harper McDowell

(a) RESIDENCE NO. 2721 Parkwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret V. McDowell

6 DATE OF BIRTH (month, day, and year): July 29 1839

7 AGE: Years 83 | Months 6 | Days 8 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer): Retired.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Newark Del

PARENTS

10 NAME OF FATHER: James McDowell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Hannah Hupman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Newcastle Co Del.

14 Informant: Joseph H McDowell
(Address) 2721 Parkwood Ave

15 Filed ..... 19 ..... Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1st 1923 to March 6th 1923.

that I last saw him alive on March 6th 1923

and that death occurred, on the date stated above, at 1.35 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Elbert C. Reitzel M. D.

3/7 1923 (Address) Cor. Pa. & Fulton Ave. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery. DATE OF BURIAL: Mar 10 1923

20 UNDERTAKER: Wilson & Goe ADDRESS: 1723 Pa Ave

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D73537

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73537

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 W. Lafayette Ave ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie A. Healey.

(a) RESIDENCE NO. 1705 W. Lafayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middletown Md

PARENTS

10 NAME OF FATHER Alfred Healey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann Downing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm H. Healey

(Address) 1705 W. Lafayette Ave

15 Filed Mar 8 1923 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923, to Mar 7, 1923,

that I last saw her alive on Mar 6, 1923,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus, bladder & rectum

(duration) 1 yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer C. Todd, M. D.

3/8, 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 8 1923
20 UNDERTAKER Wilson & Son	ADDRESS 1723 W. Lafayette Ave

MARGIN RESERVED FOR BINDING

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73538

D73538

CERTIFICATE OF DEATH.

90

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 S. Luzerne St.; 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline King

(Residence in Baltimore: No. 735 S. Luzerne St.; 58 yrs., — mos., — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 26, 1865 (Month) (Day) (Year)

7-AGE, 58 yrs. — mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Paul L. Sieber

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Josephine Budenbaum

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. J. F. King

(Address) 735 S. Luzerne St.

15-

Filed MAR 8 - 1923, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 8, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1922, to Mar 8 1923, that I saw h— alive on Mar 7 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

3.

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Valvular Heart Dis

(Duration) ...yrs. ...mos. ...ds.

(Signed) E. A. Meyer M. D.

3/8, 1923 (Address) 1138 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Mar. 11., 1923.

20-UNDERTAKER Peter Nicolaus

ADDRESS 2060 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D73539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73539

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 716 Monumental Rd St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emma Alt

(a) Residence No. Monumental Rd St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widow, ~~Widowed~~, ~~or Divorced~~. (Write the word.)

5a-If ~~married,~~ widowed, ~~or divorced~~ ~~HUSBAND of (or)~~ WIFE of Joseph Alt

6-DATE OF BIRTH (month, day and year) Feb 24 1864

7-AGE, 56 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town)..." ...
(State or Country),

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town)..." ...
(State or Country),

14- (Informant) Henry Borthling

(Address) 114 S. Eden St.

15- Filed Nov 8 1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 7th

17- I HEREBY CERTIFY, That I attended deceased from January 15th 1923 to March 7th 1923, that I last saw her alive on March 4 1923 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. 1 mos. 14 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Caleb W Bliss, M. D.

March 8, 1923 (Address) 104 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Cemetery — DATE OF BURIAL, Mar 17, 1923

20-UNDERTAKER, Wm. Leoff — ADDRESS 507 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73540

D73540

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 E. Hartford ST., 9 WARD)

2-FULL NAME Addison. Walker.

(a) RESIDENCE NO. 1127 E. Hartford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary L. Walker.

6 DATE OF BIRTH (month, day, and year) Aug 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 68—

(b) General nature of Industry, business, or establishment in which employed (or employer) Grocer & Meat Dealer

(c) Name of employer Nat. Bank

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Bennett Walker

11 BIRTHPLACE OF FATHER (city or town) ..... Md
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Durham.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Mary L. Walker
(Address) 1127 E. Hartford

15 Filed MAR 8 1923, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7th 19 23

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th 19 22, to March 7th 19 23, that I last saw h[illegible] alive on March 7th 19 23, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Dropsy & Stenosis Mitral Valve

11
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY Facies Fortunata
(Secondary)
(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. H. Taylor, M. D.

Mar 8, 19 23 (Address) 1501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 10 1923
20 UNDERTAKER	ADDRESS
Wm. Cook	1002 E. Hartford

Spec—12-23-21—E.S.R.S.—400 Bks.

D73541 HEALTH DEPARTMENT—CITY OF BALTIMORE D73541

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 505 Franklin Terrace Ward) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wesley Darrell

(a) Residence No. 505 Franklin Terrace Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Sylvia

6-DATE OF BIRTH (month, day and year) Oct 5 1852

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Thomas Darrell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Jane Furman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penn

14- (Informant) Edwin H. Darrell
(Address) 505 Franklin Terrace

15- Filed MAR 8 1923 Robert F. Harrison, Registrar.
Deputy Health Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mch 6 1923

17- I HEREBY CERTIFY, That I attended deceased from February 1, 1923, to March 6, 1923, that I last saw h. alive on March 6 19.., and that death occurred, on the date stated above, at 7-25 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 1 year mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis*

(Signed) George M. Little, M. D.

March 8, 1923 (Address) 1 E 1030 Mary Land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL, Mch 8 1923.

20-UNDERTAKER, H. Cook ADDRESS 512 E Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73542

D73542

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 657 E Clement St., 24 WARD)

2-FULL NAME Ella May Fitzpatrick

(a) RESIDENCE NO. 657 E Clement St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Female white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Fitzpatrick

6 DATE OF BIRTH (month, day, and year) 5/7/82

7 AGE: Years 40 Months 10 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jno W Hawkins.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bath England

12 MAIDEN NAME OF MOTHER Florence Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Hawkins 657 E Clement St.

15 Filed MAR 8 - 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1922 to Mar 7 1923.

that I last saw her alive on Mar 6 1923,

and that death occurred, on the date stated above, at 1130 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Thos [illegible] M. D.

(Address) 1 E Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	3/9/23 19
20 UNDERTAKER	ADDRESS
J J Fahey & Sons	1318 Eutaw

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73543

CERTIFICATE OF DEATH.

101-001 D73543

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 E. Lexington ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Josea

(a) RESIDENCE No. 1127 E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE: Years 34 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lucie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Carrie E. Jones

(Address) 1127 E. Lexington

15 Filed MAR 9 - 1923 19

ROBERT R. KRAUTER, Registrar

MAR 9 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/3, 1923, to 3/8, 1923, that I last saw h[illegible] alive on March 7, 1923, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Robinson, M. D.

19 (Address) 1520 E. Monument St

3/8/23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Va. | DATE OF BURIAL: March 9 1923

20 UNDERTAKER: Chas. T. Johnson 416 N. | ADDRESS: Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73544

CERTIFICATE OF DEATH.

100-001 D73544

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry

(a) RESIDENCE No. 650 Washington Boulevard WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, (Widowed) or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portland Maine

PARENTS

10 NAME OF FATHER John J Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utica New York.

12 MAIDEN NAME OF MOTHER Annie Lauders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portland Maine

14 Informant Hospital Records (Address)

15 Filed MAR 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/1923

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 1923, to 3/6, 1923.

that I last saw h[illegible] alive on 3/6, 1923.

and that death occurred, on the date stated above, at 6.50 m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Grippe Broncho Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Leon Bordon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL March 9 1923.

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73545 HEALTH DEPARTMENT—CITY OF BALTIMORE D73545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... St.: 6 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Isaac Walker

(a) RESIDENCE. NO. Bayford, Va. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. Two weeks ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Esther B Walker

6 DATE OF BIRTH (month, day, and year) 1855-10-26

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Merchant & Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabella Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr J C Walker (Address) Virginia

15 Filed MAR 9 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to March 9, 1923, that I last saw him alive on March 9, 1923, and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebellum
Chronic phthisis
Chr. pneumonitis
(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia
(duration) 2 weeks yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 1 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. C. Rice, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nassawadox Va	3-9 1923
20 UNDERTAKER	ADDRESS
Henry W Fentress & Sons Co	Mitchells Orchard

D73546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73546

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 904 N. EDEN St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME OTTO KNOCHE

(Residence in Baltimore: No. 904 N. EDEN St.; yrs. 69 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	widower

6-DATE OF BIRTH. April 8/1853 (Month) (Day) (Year)

7-AGE. 69 yrs. 10 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Watchman

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Frank Knoche

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Schnedler

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Knoche
-OPR-904 N. Eden
(Address)

15- Filed ROBERT R. KRAUTER, Registrar.
MAR 10 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 6/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insuffiency

Probably for several months (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis. (Duration) yrs. mos. ds.

(Signed) J. E. H. Pollitz M. D. (Coroner.)

3/7/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem.	March 9 1923
20-UNDERTAKER.	ADDRESS
Frank A. Fink	915 N. Gay St

Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1847 N. Chester ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Rittershofer

(a) RESIDENCE NO. 1847 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Rittershofer

6 DATE OF BIRTH (month, day, and year) Jan 9 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brewer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Rittershofer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ——

14 Informant Henry Rittershofer

(Address) 2056 Harford Ave

15 MAR 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 8, 1923

that I last saw him alive on March 7, 1923

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (apoplexy)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Dowden, M. D.

3/8, 1923 (Address) 1507 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Com.	March 9 1923
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

WIETSCHER ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73548 31 D73548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N Port ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Wietscher

(a) RESIDENCE NO. 808 N Port ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 20, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 69

(b) General nature of industry, business, or establishment in which employed (or employer) Grey Anthony

(c) Name of employer Establishment

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edmund Wietsche

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Wahl

13 BIRTHPLACE OF MOTHER (city or town) Buffalo (State or country) Md

14 Informant Henry Wahl

(Address) 1903 Madison Ave

15 MAR 8 - 1923

Filed , 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17

I HEREBY CERTIFY, That I attended deceased from June 1922, 19—, to March 7, 1923,

that I last saw her alive on Feb 20, 1923,

and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. Kemmler, M. D.

3-7, 1923 (Address) 3002 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cemetery	March 10 1923
20 UNDERTAKER	ADDRESS
Jas E. Grillet	2334 Jeffers St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D73549

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael O'Connor

(Residence in Baltimore: No. 1833 Orleans St.; 50 yrs., 9 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. May 22 (Month) (Day), 1872 (Year)

7-AGE. 50 yrs. 9 mos. 14 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE. (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Michael O'Connor

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dorthy Adams

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. O'Connor

(Address) 1833 Orleans st.

15- MAR 9 - 1923 Filed, 191

ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 23 1923, to Mar 8 1923, that I saw him alive on March 8 1923, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension; cerebral hemorrhage. (Duration) Due yrs. — mos. ds.

(Signed) L. R. Lucas M. D.

March 8, 1923 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 13 ds. In the State 50 yrs. 9 mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1833 Orleans St, Baltimore, Md.

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, 3/12, 1923

20-UNDERTAKER Wm. M. Gawthrop

ADDRESS 2839 Raynor

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73550

D73550

CERTIFICATE OF DEATH.

X 74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Lawless

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD. Phila Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? 70 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawless

6 DATE OF BIRTH (month, day, and year) about 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	75	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Isaac Lawless

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dunkii Ireland

12 MAIDEN NAME OF MOTHER Katherine O'Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dublin Ireland

14 Informant (Address) Records of Mt Hope Retreat

15 Filed MAR 9 - 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to March 8th, 1923, that I last saw her alive on March 8th, 1923, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-Post
Cerebral Arterio-Sclerosis-
(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Senile Psychosis-
Cyst (duration) 12 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

March 9, 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phila Penna	Mar 9 1923
20 UNDERTAKER STEUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rls.

D73551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73551

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3419 Elliott St. ST., 26 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hammen

(a) RESIDENCE NO. 3419 Elliott St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Madeline Hammen

6 DATE OF BIRTH (month, day, and year) March 10-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER George Hammen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Figg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Madeline Hammen
(Address) 3419 Elliott St.

15 Filed MAR 8 - 1923 ROBERT B. KRAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/1, 1923, to 3/6, 1923, that I last saw h[illegible] alive on 1/5, 1923, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Sadler, M. D.

3/8, 1923 (Address) 3525 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	March 10 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler.	408 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73552

CERTIFICATE OF DEATH.

21 D73552

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Frata

(a) RESIDENCE NO. ~~15 Belair Market~~ 925 Fell st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
79	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Frata

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address)

15 Filed ..., 19 ... ROBERT E. KRAUTER, Registrar

MAR 9 - 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1923

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1923, to March 5, 1923, that I last saw him alive on March 5, 1923, and that death occurred, on the date stated above, at 6:50 P.M.

The CAUSE OF DEATH* was as follows:

Facial erysipelas

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde Reed M. D.

3-6-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Mch 9 1923
20 UNDERTAKER	ADDRESS
Lilly and Zeiler	403 S. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73553

CERTIFICATE OF DEATH.

100-801

D73553

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Cereal ST. 25 WARD)

2-FULL NAME Pawel Gentiekl

(a) RESIDENCE NO. 14 Cereal ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Stanislaw Gentiekl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Antonia Gardoekl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant V. Gentiekl

(Address) Curtis Bay

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3rd, 1923, to Nov 7th, 1923.

that I last saw alive on Nov. 6th 1923

and that death occurred, on the date stated above, at 7 P.M. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam

(Signed) A Kuchinski, M. D.

, 19 (Address) 1340 Edmonson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL 3/9 1923

UNDERTAKER Wm F. Allcroft — ADDRESS 167 Eastern ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73554

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Preston Apartments ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet B. Rouse

(a) RESIDENCE. No. Preston Apartment ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Rouse

6 DATE OF BIRTH (month, day, and year) Apr 8. 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Thomas Hanway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah A. Keen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edgar S. Rouse (Address) Preston apts

15 MAR 9 - 1923 ROBERT R. KRAUTER (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1923, to March 8, 1923

that I last saw her alive on Mar 7, 1923

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis

Cerebral Softening

Chr. Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

1923 (Address) 42 Preston St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon Harford Co.	March 10 1923

20 UNDERTAKER John O. Mitchell ADDRESS 130 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73555 HEALTH DEPARTMENT—CITY OF BALTIMORE D73555

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Bolton ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary P. Herman

(a) RESIDENCE. NO. 1215 Bolton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles P. Herman

6 DATE OF BIRTH (month, day, and year) Dec 3. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house duties

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Penna

PARENTS

10 NAME OF FATHER Richard S. Pomeroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Josephine E. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Chas P. Herman 1715 Bolton St

15 Filed , 19 Registrar

MAR 8 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1923, to Mar 8, 1923

that I last saw her alive on Mon 8, 1923

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia (Bilateral)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis. Myocardial Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

Mch 9, 1923 (Address) 41 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mt. Cemetery	Mch 10 1923

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73556

CERTIFICATE OF DEATH.

17 D73556

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3211 N. Charles ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Klinefelter

(a) RESIDENCE. No. 3211 N. Charles St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah B. Klinefelter

6 DATE OF BIRTH (month, day, and year) Apr 13. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Laundry Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Geo. Klinefelter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Delilah Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant George A. Klinefelter (Address) 3211 N. Charles St

15 Filed 4-12-1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 7 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/1 1922 to 2/6 1923 that I last saw him alive on 3/6 1923 and that death occurred, on the date stated above, at 5.05A m.

The CAUSE OF DEATH* was as follows:

Chronic pancreatitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyloric obstruction

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1/2/23

Was there an autopsy? no

What test confirmed diagnosis? Duodenal aspiration

(Signed) Dr. Engelbart M. D.

3/6 1923 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Mch 9 1923
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73557 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D73557

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 301 E. North ave ST., 17 WARD)

2-FULL NAME Sallie W. Shuter

(a) RESIDENCE NO. 301 E. North ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Shuter

6 DATE OF BIRTH (month, day, and year) May 5 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Wm. B. Waldran

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Sabra A. Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Wm. E. Shuter
(Address) 2300 Garrison ave

15 Filed -1923 ROBERT R. KRAUTER, Burial Permit Clerk. 16 Registrar John O. Mitchell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28th, 19..., to March 8th, 1923, that I last saw her alive on March 8th, 1923 and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Influenza

0 (duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical Clin.

(Signed) D. A. Waldran, M. D.

, 19 (Address) 210 East Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Mch	10 1923
20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Blks.

D73558

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73558

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH 527 S. Chapel St. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Sulisczerska

(Residence in Baltimore: No. 527 S. Chapel St. St.; 25 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, ... (Month) Unknown (Day), 1 (Year)

7-AGE, 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework C. 1
(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, John Lisinski

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Sulisczerska

(Address) 527 S. Chapel St.

15- ROBERT R. KRAUTER.

Filed AUG 2 1923 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-15 191 23 to 3-7 191 23

that I saw h[illegible] alive on 3-7 191 23

and that death occurred, on the date stated above, at 3 20 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) [illegible] M. D.

3-9 23 (Address) 800 N. Watt Alley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem. DATE OF BURIAL, March 10, 1923

20-UNDERTAKER Jacob Fiedkowski ADDRESS 825 S. Bond St.

Spec.—1-10-21—M&T—1500 Blks.

D73559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73559

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew

CITY OF BALTIMORE, (No. aged Home ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Goldstein

(a) RESIDENCE NO. 115 aisquith st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 31 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Goldstein

6 DATE OF BIRTH (month, day, and year) Nov 20 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 Eastern Ave

15 Filed ..... 19... HUBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 8, 1923, that I last saw him alive on March 1, 1923, and that death occurred, on the date stated above, at 9:15 p. m.

The CAUSE OF DEATH* was as follows:

General paralysis

(duration) yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Meyer Gaylen, M. D.

3/9, 1923 (Address) 210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	March 19 23
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73560 HEALTH DEPARTMENT—CITY OF BALTIMORE D73560

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2220 Mt. Holly ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide E. Parson

(a) RESIDENCE NO. 2220 Mt. Holly St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Stowes Parson

6 DATE OF BIRTH (month, day, and year) Dec 29, 1846

7 AGE: Years 76 | Months 2 | Days 10 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa.

PARENTS

10 NAME OF FATHER: Ralph W. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia Pa

12 MAIDEN NAME OF MOTHER: Debra Shields

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Philadelphia Pa

14 Informant: Mrs Mc Donnell

(Address): 2220 ~~Harrison~~ Mt Holly

15 Filed MAR 9 1923, 19 ROBERT [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 8, 1923, that I last saw her alive on March 8, 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

I Acute parenchymatous nephritis

Lobar pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wilbert Tyblet, M. D.

3/8, 1923 (Address) 2220 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Devon. Penna

DATE OF BURIAL: MAR 10 1923, 19

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73561

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3324 E. Balto ST., 76 WARD)

2-FULL NAME Chas. H. Kratsch

(a) RESIDENCE NO. 3324 E. Balto ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? 42 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Louise Kratsch

6 DATE OF BIRTH (month, day, and year) Jan 31-57

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Kratsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Kratsch
(Address) 3324 E Balto

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 14 1922 to ..... 1923.

that I last saw him alive on Feb. 28, 1923,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cancer Rectum

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) obstruction (colostomy)

(duration) ..... yrs. 7 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Aug 14/23

Was there an autopsy? no

What test confirmed diagnosis? Appearance & clinical test

(Signed) Ina Linthicum, M. D.

(Address) 1025 East Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL 3/9 1923

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Blks.

D73562 HEALTH DEPARTMENT—CITY OF BALTIMORE D73562

CERTIFICATE OF DEATH. Ahl 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 E. Lombard ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis [redacted] Ahl

(a) RESIDENCE NO. 3508 E. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lena Ahl

6 DATE OF BIRTH (month, day, and year) Aug 7 — 84

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jos. Ahl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lena Ahl

(Address) 3503 E. Lombard

15 Filed MAR 3 1923, 19 ..... Registrar

ROBERT R. KRAUSS
Board Health Commissioners

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8/ 19 23

17 I HEREBY CERTIFY, That I attended deceased from February 25, 1923, to March 8 1923.

that I last saw him alive on March 8, 1923.

and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure & Urinary findings

(Signed) Thomas J. White, M. D.

, 19 (Address) 451 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Mar 10 1923

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73563

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D73563

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 1 WARD)

2-FULL NAME Pauline Pasyezk

(a) RESIDENCE No. 2310 Essex St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
85	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed ....., 19 ROBERT R. KRAUTER, Social Service Chief

MAR 9 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17 I HEREBY CERTIFY, That I attended deceased from February 15, 1923, to March 7, 1923, that I last saw her alive on March 7, 1923, and that death occurred, on the date stated above, at 11:55 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post

(Signed) [illegible], M. D.

3/8/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
H. Stanislaus Cem.	Mar. 10-1923
20 UNDERTAKER M. F. Sadowski.	ADDRESS 405 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73564 HEALTH DEPARTMENT—CITY OF BALTIMORE D73564

CERTIFICATE OF DEATH. 1923 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospittal St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Westcoat

(Residence in Baltimore: No. Belair Md. St.; yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White (Colored)

5-Single, Married, Widowed or Divorced (Write the word.): Married

6-DATE OF BIRTH: Dec (Month) 10 (Day) 1882 (Year)

7-AGE: 40 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Noah Westcoat

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Lizzie Sprigg

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hall Westcoat

(Address) Belair Md.

15- FILED MAR 9-1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) THE (Day) 8 (Year) 1923

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of glottis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngitis

(Duration) yrs. mos. 3 ds.

(Signed) J S Hatter M. D. (Coroner.)

3/9/23 1923 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Belair Md

19-PLACE OF BURIAL OR REMOVAL: Hendon's Hill, Md. DATE OF BURIAL: Mar 19 1923

20-UNDERTAKER: Chas O Mitchell ADDRESS 1201 Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D73565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73565

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John C. Wylie

(a) Residence No. 55 North Stiles St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Fireman

(b) General nature of industry, business, or establishment in which employed (or employer). 86

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Scotland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Scotland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Scotland

14- (Informant) Mercy Hospital

(Address) Records

15- Filed MAR 9 - 1923 ROBERT R. KRAUTER, Registr.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 7- 23

17- I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923. to Mar 7, 1923.

that I last saw him alive on Mar 7, 1923.

and that death occurred, on the date stated above, at 7.05 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Lung

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Segrs

(Signed) L. F. Bassagno M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery — DATE OF BURIAL. Mar 10, 1923

20-UNDERTAKER. John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D73566

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D73566

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE (No. 1426 John St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Phelps

(a) Residence No. 1426 John St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 67 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hotel Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Dies

9-BIRTHPLACE (city or town). (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town). (State or Country).

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town). (State or Country).

14- (Informant) De Witt H Phelps

(Address) Hamilton Md

15- Filed MAR 9 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/7/23

17- I HEREBY CERTIFY, That I attended deceased from March 1st, 1923 to March 7, 1923 that I last saw h. alive on March 7th 1923 and that death occurred, on the date stated above, at 9.45 P. M. The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

6 days (Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

1 day (Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? Hotel Altamont

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Daniel H Fowler M. D

, 19 (Address) 1405 Eutaw Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL CREMATION OR REMOVAL.	DATE OF BURIAL,
Baltimore County	March 9, 1923
20-UNDERTAKER.	ADDRESS
George J Smith	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73567

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1134 Bareley St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth McLaughlin

(Residence in Baltimore: No. 1134 Bareley St.; yrs., 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: Aug (Month) 27 (Day) 852 (Year)

7-AGE: 70 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Ireland

PARENTS:

10-NAME OF FATHER: Michael McDevitt

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Curtin

(Address) 1622 Barclay St

15- FILED MAR 3 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 7 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

fracture of Hip

neck of femur

(Duration) ....yrs. ....mos. 13 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) ....yrs. ....mos. 6 ds.

(Signed) James H. Fenton M. D. (Coroner.)

Mar 8 1923 (Address) 700 E Chase

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Holy Cross — DATE OF BURIAL: Mar 10, 1923

20-UNDERTAKER: W. C. Wiedefeld — ADDRESS: 914 Greenmount Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER. WITH CARBON PAPER.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73568 ✓ 74-001 D73568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Robert ST., 14 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Uguma

2-FULL NAME Richard Mayden

(a) RESIDENCE NO. 530 Robt. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 6 Feb 28-1861

7 AGE 61 Years 1 Months 8 Days If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Farm Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER John Mayden

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant Lavinnia Palmer (Address) 530 Robert St

15 MAR 9-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/5 1923, to 3/7 1923, that I last saw h[illegible] alive on 3/7 1923, and that death occurred, on the date stated above, at 10 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy & Paralysis

(duration) yrs. ..... mos. 2 da.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Bart Chitty M. D.

3/9 1923 (Address) 1135 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Richmond Co Va — DATE OF BURIAL 3-9 1923

20 UNDERTAKER George H. Holland — ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 D73569

CERTIFICATE OF DEATH.

100-001 D73569

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Rodgers

(a) RESIDENCE NO. 1356 N. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt.
(State or country)

PARENTS

10 NAME OF FATHER Charles Rodgers

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Frances Miller

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 MAR 9 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6th, 1923, to March 8, 1923, that I last saw him alive on Mch. 8th, 1923 and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Bronchial
Acute Cervical Adenitis

(duration) yrs. 2 mos 24 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2-1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 15th 1923
20 UNDERTAKER	ADDRESS
Clarence E. Wright	1647 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73570 HEALTH DEPARTMENT—CITY OF BALTIMORE D73570

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 914 E. Eager ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Serafina Di Giorgio

(a) RESIDENCE NO. 914 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Nov. 23. 1921

7 AGE: 1 Years 3 Months 13 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Giuseppe Di Giorgio

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosolia Donisa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Giuseppe Di Giorgio 914 E. Eadger st.

15 Filed MAR 8 - 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Febry 27, 1923, to Mch 8, 1923, that I last saw her alive on Mch. 8, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No, Date of —

Was there an autopsy? No,

What test confirmed diagnosis? —

(Signed) C. J. Castelli, M. D.

, 19 (Address) 335 E 31st St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincent's Cem — DATE OF BURIAL: 3/9/23 19

20 UNDERTAKER: Geo. D. Pentz — ADDRESS: 1735 Hanford

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D73571

D73571

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 E. Eager ST., 10 WARD)

2-FULL NAME Hannah E. McCrory

(a) RESIDENCE NO. 807 E Eager ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of the late William McCrory

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Clark

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Fox

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. Marie E. McCrory

(Address) 807 E Eager St

15 MAR 9-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to Mar 8, 1923, that I last saw h alive on Mar 8, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Renton M. D.

3/9, 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL March 13, 1923

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

D73572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 38 D73572

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alex Schilansky

(Residence in Baltimore: No. Johns Hopkins Hospital ST.; — yrs., 4 mos. 9 ds.)
Thomas, W. Va.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 7 (Day), 1895 (Year)

7-AGE, 27 yrs. 9 mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Ex-Soldier formerly ran pool room
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) West Virginia

PARENTS.

10-NAME OF FATHER, Barney Schilansky

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Cohen

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1739 E. Balto.

15- Robert P. Harrison,

Filed....., 191.....

Burial Permit Clerk, Registrar.

9-1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 9 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1922, to March 9 1923, that I saw h im alive on March 9 1923, and that death occurred, on the date stated above, at 4 15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis (Gumma?)

(Duration) One Yr. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) — yrs. — mos. 7 ds.

(Signed) L. E. Loeshe M. D.

March 9, 1923. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 4 mos. 9 ds. In the State 0 yrs. 4 mos. 9 ds.

Where was disease contracted, if not at place of death? West Virginia

Former or usual residence Thomas, West Virginia

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet, Irvington DATE OF BURIAL, March 9, 1923

20-UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73573 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73573

161-001

CERTIFICATE OF DEATH [redacted] No.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 E. Oraton St., 7 WARD)

2-FULL NAME Baby Weis

(a) RESIDENCE NO. 1718 E Oraton St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stay

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Weis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed MAR 9 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h[illegible] alive on March 8 , 1923, and that death occurred, on the date stated above, at 3 00 P m.

The CAUSE OF DEATH* was as follows:

Abortion - Foetus about 5 mos

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Collenberg M. D.

March 1923 (Address) 1816 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	3/9 1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73574 ✓ D73574

CERTIFICATE OF DEATH.

D73574

9

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 707 W. Barre ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Solder.

(a) RESIDENCE. No. 707 W. Barre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17- 1922

7 AGE 1 Years 11 Months 11 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Solder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Victoia Sakaloski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John Solder
(Address) 707 W Barre Street

15 Robert P. Harrison, Registrar

MAR 9 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1923, to Mar. 8, 1923, that I last saw h[illegible] alive on Mar. 9, 1923, and that death occurred, on the date stated above, at 2.00 a.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Harvey Boyd, M. D.

Mar. 9, 1923 (Address) 602 Wash. Blvd. Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 10. 1923
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73575

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73575

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Valley, ST., 10 WARD)

2-FULL NAME Mary Elsner

(a) RESIDENCE No. 1003 Valley ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
WIFE of (or) HUSBAND of Gilly Elsner

6 DATE OF BIRTH (month, day, and year) June 17, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Tony Gatzner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Rose Elsner 1003 Valley St

15 MAR 9-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 24 .1923. to Mar 8 .1923.

that I last saw he alive on Mar 8 .1923.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Damolar, M. D.

.19 (Address) 201 S Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Mar. 10 1923
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Eutaw

Spec.—6-9-19—H. P. Co.—1000 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73576 ✓

CERTIFICATE OF DEATH. 100-001

D73576

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 E. Hilling St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gruffen

(a) RESIDENCE. NO. 409 E. Hilling ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Gruffen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Dooley —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Murray.

(Address) 1508 N Kenwood Ave

15 Filed MAR 9 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 2 1923, to March 8 1923,

that I last saw h alive on March 8 1923,

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D Wallace, M. D.

3/9, 1923 (Address) 299 Williams Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Mar 10 1923

20 UNDERTAKER Margaret E. Flynn ADDRESS 1427 E 21 St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73577

CERTIFICATE OF DEATH.

113 D73577

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3715 East Baltimore ST. No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Regina Fousek

(a) RESIDENCE. NO. 3715 East Baltimore St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single (Infant)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 15th 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore City. (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Fousek

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) City, Maryland.

12 MAIDEN NAME OF MOTHER Mary Nestney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) City, Maryland.

14 Informant Joseph Fousek (Address) 3715 East Baltimore St.

15 Filed MAR 9 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from February 15th, 1923, to March 9th, 1923, that I last saw her alive on March 9th, 1923, and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion.

..... (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diarrhoea

..... (duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. Woodward, M. D.

. 19 (Address) 4 North Front St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st United Evangelical Lutheran	Mar 7th 1923
20 UNDERTAKER	**ADDRESS**
George Schilling & Sons	1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73578

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73578

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 541 N. Pulaski St. ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Preston W. & Clarissa Jordan

(a) RESIDENCE NO. 541 N. Pulaski St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 5th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Preston W. Jordan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Clarissa Emerick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Preston W. Jordan
(Address) 541 N. Pulaski St.

15 MAR 9 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 5th, 1923, to mar 9, 1923.

that I last saw her alive on mar 8, 19....

and that death occurred, on the date stated above, at 8.45 A.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis of mother

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Gradual failure of heart

(Signed) Thos. H. Phillips M. D.

3/9. 1923 (Address) 2300 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Mar. 10 1923
20 UNDERTAKER	ADDRESS
Jas. B. Cook	1003 W. Baltimore St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

~~16624~~
D73579

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-003 D73579

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 18

CITY OF BALTIMORE: (No. ..... ST., WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Barry

(a) RESIDENCE NO. 107 Scott ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Oct 31-922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Millard Barry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella M.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed MAR 9 1923, 19 Robert B. Harrison, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 9th 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 11th, 1923, to Mch 9th, 1923, that I last saw h alive on March 9th, 1923, and that death occurred, on the date stated above, at 4 15 a. m.

The CAUSE OF DEATH* was as follows:

acute Dysentery. (1 mo).

Streptococcus pharyngitis

& otitis media

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Streptococcus septicemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes Stool

What test confirmed diagnosis? Blood culture

(Signed) Horton Casparis M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carthedral — DATE OF BURIAL 3/12 1923

UNDERTAKER Wm Cook — ADDRESS 502 E North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73580

CERTIFICATE OF DEATH.

90 D73580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3005 St Paul ST. 17 WARD)

2-FULL NAME Juliet Jeffries Woodward

(a) RESIDENCE NO. 3005 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 30 1862

7 AGE: Years 60; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER R. H. Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Susan P Ballard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant R. H. Woodward Jr

(Address) 501 Edmondt

15 Filed Robert J. Harrison, 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 9, 1923.

that I last saw her alive on March 9, 1923

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 7 yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Roger Mosser M. D.

3/10 1923 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: March 10 1923

20 UNDERTAKER: Henry Hankins & Son — ADDRESS: Oakland & McCulloh Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N 10 1923

Spec.—1-1921—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73581

CERTIFICATE OF DEATH.

179 ✓ D73581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Wilkens Ave ST., 19 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Comm

(a) RESIDENCE No. 1619 Wilkens Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced (or) WIFE of John H Comm

6 DATE OF BIRTH (month, day, and year) July 17-1849

7 AGE — Years 74 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or ~~employer~~) Housework

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Comm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Andrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Oliver C Comm
(Address) 1619 Wilkens Ave

15 Filed MAR 10 1923, 19 .....
Robert F. Harrison,
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 ....., 1923, to March 7, 1923, that I last saw h[illegible] alive on March 7, 1923, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis. Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert C Mitchell, M. D.

3/9/1923 (Address) 2157 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 3/10 1923

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D73582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73582

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casimer Kulczynski.

(a) RESIDENCE. NO. 3119 Fait Ave. ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1918 - March 2

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Sygmund Kulczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Jozefa Ziemkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sygdmund Kulczynski
(Address) 3119 Fait Ave

15 Filed MAR 10 1923 Robert F. Harrison Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1923

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1923, to March 9, 1923 that I last saw him alive on March 9, 1923. and that death occurred, on the date stated above, at 1 55 A. m.

The CAUSE OF DEATH* was as follows:

General Sepsis
Staphylococcus

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. & S. - Laboratory

(Signed) J. K. Jezerbicki, M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Mar 12 1923
20 UNDERTAKER	ADDRESS
Stephen J. Frackowski	1000 S Spring Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D73583

CERTIFICATE OF DEATH.

162 D73583

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 Baker St. 15 WARD)

2-FULL NAME Harlan John Motley Jr.

(a) RESIDENCE. No. 1627 Baker St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 7-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harlan J. Motley Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Ada B. Lambe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Harlan J. Motley Sr
(Address) 1627 Baker St

15 Filed . 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9th 1923

17

I HEREBY CERTIFY, That I attended deceased from March 7th, 1923, to the March 9th, 1923, that I last saw him alive on March 9th, 1923, and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis:

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) 8 minutes pregnancy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fair Lawn

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J. Sullivan, M. D.

3/9, 1923 (Address) 1701 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Park Cemetery	March 10 1923
20 UNDERTAKER	ADDRESS
H. M. Cookson	2301 W Lanvale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73584

CERTIFICATE OF DEATH.

181-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 411 N Fremont St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Woods

(Residence in Baltimore: No. 411 N Fremont St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widow or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. 26 (Month) 61 (Day) 1872 (Year)

7-AGE. 51 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lithographer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Vermont

PARENTS.

10-NAME OF FATHER. Geo H Woods

11-BIRTHPLACE OF FATHER, (State or Country). Vermont

12-MAIDEN NAME OF MOTHER. Deborah

13-BIRTHPLACE OF MOTHER, (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Woods

(Address) 140 - 7th Ave New York City

15- Mar 28 1923 Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 7 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gas Inhalation

(Duration) a few hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Accident

(Duration) a few hours yrs. mos. ds.

(Signed) H K Jarvis of (Coroner.) M. D.

3-10 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	March 10 1923
20-UNDERTAKER.	ADDRESS
W M Routson	230 N Greene

Burial Permit Clerk.

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73585

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Stemts Lt ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert P. Snyder

(a) RESIDENCE NO. 1107 Stemts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 20 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or estsblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Herbert Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary. Eeske.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Herbert Snyder.

(Address) 1107 Stemts ST

15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1923, to March 8, 1923.

that I last saw him alive on March 8th 23 at 10 4 P m.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What teat confirmed diagnosis?

(Signed) J E Poulton M. D.

3/9, 1923 (Address) 3909 Gamsonane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3-10 1923

20 UNDERTAKER James Dignan & Son

ADDRESS 1000 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

10 1923 Burial Permit

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Phoebus)

HEALTH DEPARTMENT—CITY OF BALTIMORE D73586

D73586

CERTIFICATE OF DEATH.

(Hamilton) 74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Shirley Ave ST.: 2 WARD)

2-FULL NAME Indiana Phoebus

(a) RESIDENCE. NO. 15 Shirley Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. \ mos. \ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of George W. Phoebus

6 DATE OF BIRTH (month, day, and year) Jan 8-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Maryland.

PARENTS

10 NAME OF FATHER Levin Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Hinderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs Carrie Smith
(Address) 15 Shirley ave. Hamilton

15 Filed APR 10 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923 to Mar 8, 1923 that I last saw h alive on Mar 8, 1923 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Cerebral arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Deering, M. D.

3/9, 1923 (Address) 4206 Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Somerset Co Md.	3/12/23

20 UNDERTAKER A E Hughes ADDRESS 1 N Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73587

CERTIFICATE OF DEATH.

100-001

D73587

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital Asylum ST. WARD)

2-FULL NAME Mrs Rose Stern

(a) RESIDENCE NO. Hebrew Hospital Asylum (Dallas Ave.) ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hosp. Records (Address) Heb. Hosp

15 Filed MAR 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/23

17 I HEREBY CERTIFY, That I attended deceased from 2/19/23, to 3/9/23, that I last saw her alive on 3/9/23, and that death occurred, on the date stated above, at 3.45 A m.

The CAUSE OF DEATH* was as follows: Mitr Carcinoma Left Br

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Confluent Bronchio Pneumonia (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Moses Seaman M. D.

Mar. 9, 1923 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	3/11 1923
20 UNDERTAKER David Sondheim	ADDRESS 115 N. Mt. Royal Ave

M. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73588

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73588

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. ~~844 S. Broadway~~ Foot E. Fells St. ~~Ward~~)

(If death occurred in a hospital or institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME... Henry Murphy

(Residence in Baltimore: No. 844 S. Broadway .....St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced. (Write the word.): Unknown

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

About 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- MAR 1923 192

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 3 (Day) 1923 (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by me, Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) hrs. mins. mos. ds.

CONTRIBUTORY (Secondary) Fell over board

(Duration) yrs. mos. ds.

(Signed) Hor. B. Horton M. D.
Coroner.

March 9 1923 (Address) Curtis Bay Balto, Md

*State the Disease Causing Death, or, In cases from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: 3 | 10 1923

20-UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D.73589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73589

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 5 WARD)

2-FULL NAME William Harper

(a) RESIDENCE NO. 1416 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept 19-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mandy Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1923 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Mch 5th, 1923, to Mch. 8th, 1923, that I last saw h...alive on Mch 8th, 1923, and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Rickets

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Horton Casparis M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Mch 10, 23
20 UNDERTAKER Wm J. G. Locke	ADDRESS 1309 Jefferson

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73590

CERTIFICATE OF DEATH.

D73590

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 43 Aisquith ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Jones.

(Residence in Baltimore: No. 43 Aisquith St.; yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, February 28, 1907
(Month) (Day) (Year)

7-AGE, 20 yrs. — mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Morgan Cole

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Anna Louise Gaines

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Williams (Sister)

(Address) 43 Aisquith St.

15-

Filed ..... 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1923.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 3. 1923, to March 8 1923, that I saw her alive on March 8 1923, and that death occurred, on the date stated above, at 6a p. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Failure of Resolution

(Duration) yrs. mos. ds.

(Signed) W. G. Sandrock M. D.

March 9, 1923 (Address) 1242 N. Broadway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Fredericksburg Va

19-PLACE OF BURIAL OR REMOVAL, Fredericksburg Va. DATE OF BURIAL, March 10 1923

20-UNDERTAKER Mary J. G. Locke ADDRESS 1302 Jefferson St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and others CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10 1923 Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1921—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73591

CERTIFICATE OF DEATH.

49

D73591

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 E. North Ave. ST. 17 WARD)

2-FULL NAME John Jillard Hyde

(a) RESIDENCE No. 100 E. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband

6 DATE OF BIRTH (month, day, and year): Feby. 17, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer): Lunch Room

(c) Name of employer: Geo. H. Hyde & Sons

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Richard Henry Hyde

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis, Md.

12 MAIDEN NAME OF MOTHER: Emily Jillard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: G. Ray Hyde.

(Address) 225 E. Baltimore St. Balto.

15 Filed ..... 19 ..... Registrar

R 10 1923

Robert F. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 1, 19 23, to March 9, 19 23,

that I last saw him alive on March 9, 19 23,

and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(Lead To)

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feby 6 23

Was there an autopsy? No

What test confirmed diagnosis? Sight Microscopic Examination

(Signed) F. J. Kirby, M. D.

3/4, 1923 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 3/10 1923

20 UNDERTAKER: Henry W. Means & Son

ADDRESS: 805 N. Calvert St

Spec.—1-10-21—M&T—1500 Blks.

D73592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73592

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 Bolton Street ST. 14 WARD)

2-FULL NAME Rosalie Alrich Virdin

(a) RESIDENCE NO. 1529 Bolton St, ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph D. Virdin

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William A. Alrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Mary J. Love

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Joseph D. Virdin (Address) 1529 Bolton Street

15 Filed Robert F. Harrison, Registrar

APR 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1923, to March 9, 1923, that I last saw h[illegible] alive on March 9 1923, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Irving M. D.

3/9, 1923 (Address) 1733 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Spesutia Cemetery Perryman Md.

DATE OF BURIAL 3/12 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 Calvert St

Burial Permit. Clerk. D. Virdin Escort.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Blks.

D73593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73593

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1126 Cleveland ST. WARD 21)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Bessel

(a) RESIDENCE NO. 1126 Cleveland St. WARD 21

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, (Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George H. Bessel

6 DATE OF BIRTH (month, day, and year): Nov. 26-1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): George H. Bessel 1999 W. Fairmount Ave

15 Filed MAR 10 1923, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 9 1923

17 I HEREBY CERTIFY, That I attended deceased from March 9 1923 to March 9 1923

that I last saw h alive on March 9 1923

and that death occurred, on the date stated above, at 12:35 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Hymalysis

(Signed) John Hopkins University M. D.

1923 (Address) 1126 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Mar. 12 1923

20 UNDERTAKER: George Schwab — ADDRESS: 2101 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D73594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73594

CERTIFICATE OF DEATH.

REGISTERED No. C 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 N. Patterson Park Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Georgannie Bork

(Residence in Baltimore: No. 209 Patterson Park Ave St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 8 (Month) (Day), 1866 (Year)

7-AGE, 56 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Home
(b) General nature of industry, business, or establishment in which employed (or employer) ... Work

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Dan'l Kunz

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest D. Zuck

(Address) 209 N Patterson Park Ave

15-

Filed ... Robert P. Harrison, Registrar.

MAR 10 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 5 1923, to March 8 1923, that I saw her alive on Mar. 8th 1923, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Heart
Dilatation of Heart
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Nephritis
(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm M. Wright M. D.

Mar 10th 1923 (Address) 1801 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Dan'l Kunz Cemetery — DATE OF BURIAL, Mar 12, 1923

20-UNDERTAKER Robt. Johnson Inc — ADDRESS N. Y. Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D73595

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73595

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 235 W. Biddle St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Green

(Residence in Baltimore: No. 235 W. Biddle St. St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... 1865
(Month) (Day) (Year)

7-AGE, 58 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardener
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country). Anne Arundel Co Md

PARENTS.

10-NAME OF FATHER, Richard Green

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Green

(Address) 235 W Biddle

15.

Filed ..... Robert F. Harrison, for Registrar.

MAR 10 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer (Liver)

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. E. Hennessy M. D.
(Coroner.)

March 8 1923 (Address) 2 S. Eutaw St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Fulton Md	3/10 1923
20-UNDERTAKER.	ADDRESS
Samuel Schmeltz	578 N Biddle

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73596

CERTIFICATE OF DEATH.

11-001 ✓ D73596

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 169 W. Hamburg ST., 23 WARD)

2-FULL NAME Mary Davis

(a) RESIDENCE NO. 169 W. Hamburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Davis

6 DATE OF BIRTH (month, day, and year) ——— 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland.

PARENTS

10 NAME OF FATHER George Thomas

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Johnna Wallace

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. (State or country) Maryland

14 Informant Antie Taylor (Address) Calvert Co. Md

15 Filed APR 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar, 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb, 27, 1923, to Mar, 8, 1923, that I last saw her alive on Mar, 8, 1923, and that death occurred, on the date stated above, at 8.30, P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

Influenza.

(duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary) Hypatension, Interstitial nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Wm Francken M. D.

3/9, 1923 (Address) 1111 Mc Cul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sollers, Wlf. Calvert Co. Md

DATE OF BURIAL 3-10, 1923

20 UNDERTAKER Jno H. Toadvine

ADDRESS 142 W Hill St

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73597

CERTIFICATE OF DEATH.

57 D73597

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Landman

(a) RESIDENCE NO. 210 N. Schroeder St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
51	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Harry Landman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Municipal Hospital Records.

(Address) ~~Robert P. Harrison,~~

15 Filed MAR 10 1923 Burial Permit Clerk.

THE MORGUE.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1922, to February 28, 1923, that I last saw him alive on February 27, 1923, and that death occurred, on the date stated above, at 3:55 A.M.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed dingnosis?

(Signed) J. A. McKay M. D.

2-28 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: 3-12-1923

20 UNDERTAKER: H. B Manning Bro. — ADDRESS: 511 N. Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

74

Spec.—1-10-21—M&T—1500 Blks.

D73598

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D73598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 N. Calhoun ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Clark

(a) RESIDENCE NO. 1107 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Clark

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Mills

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Mills

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Robert Clark
(Address) 1102 N Calhoun St

MAR 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1923, to Mar 8, 1923, that I last saw her alive on Mar 7, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

3/8, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar 10 1923
20 UNDERTAKER	ADDRESS
Jno W. Johnson	1234 Etting

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D73599

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73599

CERTIFICATE OF DEATH.

X 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3063 Tayloe ST.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Ermer

(Residence in Baltimore: No. 3063 Tayloe St. St.; 9 yrs., 7 mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Nov. 26, 1883 (Month) (Day) (Year)

7-AGE, 40 yrs. 3 mos. 11 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Christopher Fisher

11-BIRTHPLACE OF FATHER (State or Country). N. Germany

12-MAIDEN NAME OF MOTHER Clarissa Knight

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Ermer

(Address) 3063 Tayloe St.

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MAR 10 1923

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 1923, to Mar 8 1923, that I saw h[illegible] alive on Mar 8 1923, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Contributory to Lobar Pneumonia

(Duration) ...yrs. ...mos. 8 da.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) ...yrs. ...mos. 1 da.

(Signed) K. P. Harrison M. D.

Mar 8, 1923 (Address) 3326 Greenmount Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...da.

Where was disease contracted, if not at place of death?

Former or usual residence Catonsville Md.

19-PLACE OF BURIAL OR REMOVAL: St. John's Cem. DATE OF BURIAL: Mar. 11, 1923

20-UNDERTAKER Adkins Bros ADDRESS Ellicott City Md

Spec.—1-10-21—M&T—1500 Bks.

D73600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D73600

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., H WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Edwards

(a) RESIDENCE NO. Institution. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Feb. 22, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	66.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital Balto. Md.

15 Filed MAR 10 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1921 to March 6 1923

that I last saw h alive on March 6 1923

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) ..... yr. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Hosp.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N. Edwards, M.D.

3/9/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAR 10 1923

20 UNDERTAKER: Commissioner Health,

ADDRESS

ROBERT F. MATTSON, Burial Permit Clerk

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73601

CERTIFICATE OF DEATH.

74-001 D73601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Harris

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co., Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1921 to March 7, 1923.

that I last saw him alive on March 6, 1923,

and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. Reese, M. D.

3-7-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

MAR 10 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 10 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73602

CERTIFICATE OF DEATH.

101-001

D73602

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Miller.

(a) RESIDENCE NO. 120 W. Mulberry ST., city WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	38	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Robert S. Little
(Address) 2700 Edmondson Ave

15 Filed ....., 19.....

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MAR 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1923

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1923, to March 9, 1923, that I last saw h[illegible] alive on 8 P.M. March 9, 1923, and that death occurred, on the date stated above, at 8.20 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? — .....

What test confirmed diagnosis? .....

(Signed) Edward A. Kotowski M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL MAR 10 1923

20 UNDERTAKER Geo W. Little

ADDRESS 2700 EDMONDSON AVE.

SPECIAL NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73603

CERTIFICATE OF DEATH.

90 D73603

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Edmondson Ave 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira Reynolds Towson

(a) RESIDENCE. No. 817 Edmondson Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Wm. O. Towson

6 DATE OF BIRTH (month, day, and year) March 15, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co Md.

PARENTS

10 NAME OF FATHER Leonard Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md.

14 Informant Mrs. Lallie T. James
(Address) 817 Edmondson Ave

15 Filed MAR 10 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923, to Mar 10, 1923

that I last saw h~~er~~ alive on Mar 9th, 1923

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteris Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) James Brown, M. D.

3/10, 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL MAR 10 1923

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 10 1923

Spec.—1-10-21—M&T—1500 Blks.

16-002 D73604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 D73604

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPIT ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Roberts.

(a) RESIDENCE NO. 1930 N. Washington St. City

(Usual place of abode) WARD .....

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: .....

6 DATE OF BIRTH (month, day, and year): July 25, 1922.

7 AGE: Years —; Months 7; Days 12.; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): (Home)

(c) Name of employer: (Home)

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Records JOHNS HOPKINS HOSPIT

15 Filed ..... 19 ..... Registrar

MAR 10 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1923, to March 9, 1923, that I last saw him alive on March 9, 1923, and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

(duration) ..... yrs. ..... mos. 8 ds. +

CONTRIBUTORY (Secondary): Primary —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes —

What test confirmed diagnosis? Autopsy,

(Signed) A. B. Wreck M. D.

, 19 (Address) Johns Hopkins Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: 3/10/1923

20 UNDERTAKER: E. O. Kenney: Inc - 1938 E. Lafayette Ave

ADDRESS

A. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—

Spec.—1-10-21—M&T—1500 Blks.

D73605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 / D73605

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

2-FULL NAME Edward Wharton

(a) RESIDENCE No. 615 Lanvale st. ST., WARD

(Usual place of abode) 8 years

Length of residence in city or town where death occurred 8 years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Wharton

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	35 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Wharton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Margaret Wharton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M. T. H.

15 Filed MAR 10 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 19 23

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1923, to March 8, 1923,

that I last saw him alive on March 8, 1923,

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 ? mos ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Steuart M. Dabogliacco, M. D.

3-8-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Va	March 11 1923
20 UNDERTAKER John H Owens	ADDRESS 5-38 Bolk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Ayers) V.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73606

D73606

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Winchester ST. 16 WARD)

2-FULL NAME John Richard Ayers

(a) RESIDENCE. No. 110 Winchester ST., WARD.

(Usual place of abode) all life (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
~~(or WIFE of)~~ Elnora Ayers

6 DATE OF BIRTH (month, day, and year) May 28 - 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day Labor 040

(c) Name of employer Eastwick Motor Co Balto.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Ayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Cecelia Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant (Address) Cecelia Ayers Oakland Md.

15 Filed MAR 10 1923, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 4, 1923, to Mar. 8 -, 1923, that I last saw him alive on Mar. 8 -, 1923, and that death occurred, on the date stated above, at 1-0 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 5 - ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. dgnsis

(Signed) Chas. T. McCathran, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar. 11 1923
20 UNDERTAKER James H. Dunn	ADDRESS 1303 Gwynn

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

665873

D73607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X49 D73607

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ferguson.

(a) RESIDENCE NO. Edgewood, Md. U. S. Arsenal ST., ... WARD Phila Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mary Ferguson (wife).

6 DATE OF BIRTH (month, day, and year) Sept 3, 1887.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35.	6.	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fire Chief.

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): " Pa

PARENTS

10 NAME OF FATHER: John H. Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country): " Pa.

12 MAIDEN NAME OF MOTHER: Lydia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Pa

14 Informant: Records JOHNS HOPKINS HOSPITAL. (Address)

15 FILED MAR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 10, 1923, that I last saw him alive on March 10, 1923, and that death occurred, on the date stated above, at 6:00 a. m.

The CAUSE OF DEATH* was as follows: Malignant tumor of Testicle

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Metastases

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Nov 7 - 1922

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Shaw M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa — DATE OF BURIAL: March 12 1923

20 UNDERTAKER: Joseph Abrens — ADDRESS: 220 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73608 ✓ 57 D73608

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ray Malman

(Residence in Baltimore: No. 1000 E. Balto. St St.) (yrs., 17 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write Word.)
female	white	Single

6-DATE OF BIRTH. Feb 13/1906 (Month) (Day) (Year)

7-AGE. 17 yrs. mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Abraham Malman

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Esther Stulman

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Balto. Md.

15- FILED MAR 11 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic Myocarditis

(Duration) 1 yrs. 1 mos. 13 ds.

(Signed) J S H Collin (Coroner.) M. D.

3/10/23 1923 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Hebrew Int. Carroll — DATE OF BURIAL. March 11 1923

20-UNDERTAKER. Jack Lewis, 1439 E. Balto. — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D73609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9° D73609

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2701 Ulman ave ST., 15 WARD)

2-FULL NAME Kalman Mopsikor

(a) RESIDENCE No. 2701 Ulman ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 38 yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Mopsikor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer) 880

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Lewis Mopsikor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sadah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Mopsikor

(Address) 2701 Ulman ave Brooklyn N.Y.

15 FILED MAR 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 27 1923 to March 8 1923, that I last saw h[illegible] alive on March 8 1923, and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows: Paroxysmal Tachycardia

(duration) yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(duration) yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Samuel Hirshstein, M. D.

3/11, 1923 (Address) 1810 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wehelem Friendship Cem — DATE OF BURIAL 3/11 1923

20 UNDERTAKER Jack Levis 1439 E Balto St — ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73610

D73610

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital Monument St & Rutland St., ave 6 WARD)

2-FULL NAME Miss Bessie Oshrine

(a) RESIDENCE NO. 1926 E. Fayette st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) December

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Work

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jascheu Oshrine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Clara Feinstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 Eutaw st.

15 Filed MAR 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1923, to March 10, 1923, that I last saw h alive on March 10, 1923, and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from stomach due to carcinoma of stomach (metastases from ovary).

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Carcinoma of ovary with metastases. (duration) yrs 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 27-23

Was there an autopsy? No Exploratory Laparotomy.

What test confirmed diagnosis?

(Signed) Adler Sonnheimer, M. D.

3/6, 1923 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 3-11 1923

20 UNDERTAKER Jack Levis 1439 Eutaw st.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Gisella Gyenes

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73611

CERTIFICATE OF DEATH.

98 D73611

REGISTERED NO.

1-PLACE OF DEATH Hebrew Home

CITY OF BALTIMORE: (No. Cutland Ave + Monk ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Gisella Gyenes

(a) RESIDENCE NO. 220 N Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ignacz A Gyenes

6 DATE OF BIRTH (month, day, and year) Nov 1 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Mayer Grossman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Hannah Grossman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Jack Levy (Address) 1439 E Baltimore ST

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

MAR 11 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 10, 1923, that I last saw h[illegible] alive on March 10, 1923, and that death occurred, on the date stated above, at 12:05 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Progressive Cerebrovascular Disease

(duration) 2 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Hypertension

(duration) 2? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Rosenbaum M. D.

3/10 1923 (Address) Hebrew Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 3/12 1923

20 UNDERTAKER Jack Levy 1439 E Balto ST

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73612

CERTIFICATE OF DEATH.

6 11-601

1-PLACE OF DEATH

City of BALTIMORE: (No. 407 N. Ann St., Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Cooperstein

(Residence in Baltimore: No. 407 N. Ann St.; 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	White	married

6-DATE OF BIRTH. Nov 1/1883 (Month) (Day) (Year)

7-AGE. 39 yrs. 4 mos. 9 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). H

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). H

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Balto. Md.

15- Filed MAR 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorruage-probably following influenzabronchitis (Duration) yrs. mos. ds.
(Remains does not look like tuberculosis.)

CONTRIBUTORY (Secondary) History of sick only 3 Weeks (Duration) yrs. mos. ds.

(Signed) J. S. H. Owen M. D. (Coroner)

3/10/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Morkmen cemetery DATE OF BURIAL. 3-11 1923

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73613 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D73613

CERTIFICATE OF DEATH. 90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Norfolk ST., 15 WARD)

2-FULL NAME Hyman Huldstein.

(a) RESIDENCE NO. 2914 Norfolk Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 25 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Esther Huldstein

6 DATE OF BIRTH (month, day, and year) — 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 880
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Balto. St.

15 MAR 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 1923, to March 10, 1923, that I last saw him alive on March 10th, 1923, and that death occurred, on the date stated above, at 330 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral embolus 2 ds.
(duration) ... yrs. ... mos. ...

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Benj. Kadrie, M. D.

, 19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Rosedale — DATE OF BURIAL 3-11-1923

20 UNDERTAKER Jacob Lewis, 1439 E Balto. — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73614

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N. Washington ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Braun.

(a) RESIDENCE NO. 518 N. Washington St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Braun.

6 DATE OF BIRTH (month, day, and year) March 31-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Germany.

PARENTS

10 NAME OF FATHER Ludwig Eyring

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Heyenhahn

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Germany

14 Informant Mrs. Elizabeth Mueller 518 N. Washington St.
(Address)

15 MAR 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1922, to March 9, 1923.

that I last saw her alive on 11 8, 1922,

and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Fatty Degeneration of Heart

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) acd agl

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Hearn M. D.

3/11, 1923 (Address) 3907 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	March 13 1923.
20 UNDERTAKER	ADDRESS
Tilly and Zeiler.	4038 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73615

CERTIFICATE OF DEATH.

90 D73615
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S Dallas St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lucas

(a) RESIDENCE. NO. 318 S Dallas ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred all 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Lucas

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Johnstown Pa

12 MAIDEN NAME OF MOTHER Elizabeth Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha Scott
(Address) 318 S Dallas St

15 MAR 11 1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 7, 1923, that I last saw h alive on March 7, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Disease

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. J. Henderson, M. D.

1923 (Address) #14 S Bl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cremation	March 11 19 23
20 UNDERTAKER John W Henderson	ADDRESS 1031 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73616

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D73616

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1341 Hull ST., 24 (WARD)

2-FULL NAME Richard L. Aguiel.

(a) RESIDENCE NO. 1341 Hull St. ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 9 / 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Leonard Aguiel

11 BIRTHPLACE OF FATHER (city or town) Brathurg Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary B. Gaithner

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Leonard Aguiel
(Address) 1341 Hull St

15 MAR 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1923, to March 10, 1923, that I last saw him alive on March 9, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(Two months premature).

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1273 William St, Health Officer

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/11 1923
20 UNDERTAKER	ADDRESS
Hall & Sidney Rowe	1312 Light St

Stoc—12-23-21—E.B.R.S.—400 Blks.

D73617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D73617

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 443 S Robison St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marianna Santetta

(a) Residence No. 443 S Robison St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widow Widowed, or Divorced, (Write the word.)
F	W	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pasquale Santetta

6-DATE OF BIRTH (month, day and year) 1856

7-AGE. 67 yrs. mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Houseduties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Penna

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER Concetta Pesca

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Joseph Penna

(Address) 443 S Robison

15- FILED MAR 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 10 1923

17- I HEREBY CERTIFY, That I attended deceased from March 9 1922 to March 9 1923 that I last saw h[illegible] alive on March 9 1923 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Heart Failure - Following acute Indigestion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

March 15, 1923 (Address) 18 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	March 12, 1923
20-UNDERTAKER. Wendell Dappledon	ADDRESS 378 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73618

CERTIFICATE OF DEATH.

90

D73618

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Clarkson & Heath Sts., St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abbott L. Mabee. 66 --- 8 --- 4

(Residence in Baltimore: No. 3028 Abel Ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Widower.

6-DATE OF BIRTH. July 4, 1856. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
66 yrs. 8 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barrel dealer.
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Thaddeus W. Mabee.

11-BIRTHPLACE OF FATHER, (State or Country). New York.

12-MAIDEN NAME OF MOTHER. Mary Stevens.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irene E. Ragland. (daughter)

(Address) 3028 Abel Ave.

15- MAR 11 1923 ROBERT R. KRAUTER,
Filed ..... 192.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to hrs death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

March 9 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	Mar 12 1923

20-UNDERTAKER. Penn Cook 502 ADDRESS E. North

Spec—12-23-21—E.B.R.S.—400 Blks.

D73619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73619

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 N. Broadway St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman E Fischer

(a) Residence No. 503 N Broadway St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia E

6-DATE OF BIRTH (month, day and year) Dec 1870

7-AGE, 52 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Herman E Fischer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Virginia Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs Kate Downey

(Address) 503 N Broadway

15-

Filed MAR 11 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mch 11 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1923 to March 11 1923

that I last saw him alive on March 10 1923

and that death occurred, on the date stated above, at 3.30 A.m.

The CAUSE OF DEATH* was as follows:

1 Mitral Regurgitation

2

(Duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Reinicke, M. D.

3-11-1923 (Address) 1001 N Patt Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore DATE OF BURIAL, Mch 13 1923

20-UNDERTAKER, Thos Corle ADDRESS 502 E Lee

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73620

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 139 E. West Street. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma I. Strack.

(Residence in Baltimore: No. 139 E. West St. St.; yrs., 63 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, Do not know. 1.....
(Month) (Day) (Year)

7-AGE, 63 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. James Carney.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Emily Rummel.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Strack. (son).

(Address) 139 E. West Street.

MAR 11 1923 Filed ..... 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 8, 1923. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

March 9, 192 3 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery.	March 12, 1923.

20-UNDERTAKER.	ADDRESS
Mrs. J.E. Evans & Son.	1428 S. Charles St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73621

CERTIFICATE OF DEATH.

91-0 02 V

D73621

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Lenox ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Estelle Walker

(Residence in Baltimore: No. 608 Lenox St.; Unknown yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, June 11 (Month) (Day) 1836 (Year)

7-AGE, 86 yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Accomac Co Va

PARENTS.

10-NAME OF FATHER, John Robertson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Ann Coates

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... B Thalau

(Address)..... 608 Lenox St

15- Filed MAR 11 1923 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 4 1923, to March 7 1923, that I saw her alive on March 7 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis & old age

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration)..... yrs. ..... mos. 11 ds.

(Signed) Thos E Hall M. D.

....., 191... (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park	Mar 11
20-UNDERTAKER	ADDRESS
J Lamb & Co	1128 N Howard St

D73622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73622

CERTIFICATE OF DEATH.

90

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 103 Prospect St ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip D. Geoghan

(Residence in Baltimore: No. 103 Prospect Ave. Roland Park St. (yrs. 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	married

6-DATE OF BIRTH. July 25, 1853
(Month) (Day) (Year)

7-AGE. 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. John Geoghan

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). John P. Geoghan

(Address) 103 Propect Ave

15- Filed MAR 11 1923, 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 9, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Salivation
Chronic Valvular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrow M. D.
(Coroner)

1923 (Address) 3672 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Lorraine Cemetery — DATE OF BURIAL. March 12, 1923

20-UNDERTAKER E. LeRoy Stidham — ADDRESS 1252 North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73623

CERTIFICATE OF DEATH.

90 D73623

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1600 Poplar Grove ST. 16 WARD)

2-FULL NAME George Henry Calder

(a) RESIDENCE. NO. 1600 Poplar Grove ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~): Florence E. Calder

6 DATE OF BIRTH (month, day, and year): July 19 1870

7 AGE — Years: 52 Months: 7 Days: 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paperhanger

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Robert Calder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland.

12 MAIDEN NAME OF MOTHER: Martha Gilbethorpe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Pa.

14 Informant: Florence E. Calder

(Address) 1600 Poplar Grove St.

15 Filed MAR 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1923

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw him alive on Mar 1. 1923 19... and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(see over)

(duration) yrs. mos. 1 hr ds.

CONTRIBUTORY (Secondary) Hypertension, Arterio Sclerosis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Horley Cole, M. D.

3/9, 1923 (Address) 2202 Fenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 3/12/23

20 UNDERTAKER: A E Hughes — ADDRESS: 4 st N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73624

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4015 Springdale Avenue ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lane

(a) RESIDENCE No. 4015 Springdale Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 35 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Lane

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	73	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired - Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 019

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Charles Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Henrietta Freund

(Address) 4015 Springdale Avenue

15 MAR 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1922, to March 10, 1923.

that I last saw him alive on March 22, 1923

and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine

(Signed) R. L. Carnes, M. D.

3.10.23. 1923 (Address) Dew Hills.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 3/12 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73625

CERTIFICATE OF DEATH.

X 45 D73625

REGISTERED NO.

1-PLACE OF DEATH Howard A Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Frank W. Sneed
Buckingham Hotel

(a) RESIDENCE. No. St Louis, Mo. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Eulalie Hockaday

6 DATE OF BIRTH (month, day, and year) Apr 22 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) Sedalia Mo.
(State or country)

PARENTS

10 NAME OF FATHER John M. Sneed

11 BIRTHPLACE OF FATHER (city or town) Kentucky
(State or country)

12 MAIDEN NAME OF MOTHER Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town) Kentucky
(State or country)

14 Informant Eulalie Hockaday Sneed
(Address) St Louis Mo

15 Filed MAR 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to Mar 10, 1923
that I last saw h.... alive on Mar 10, 1923
and that death occurred, on the date stated above, at 12:50 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of Mar 5, 23.

Was there an autopsy? No

What test confirmed diagnosis? Histological study

(Signed) Grant Edwards, M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Louis Mo.	March 11 1923
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. Pratt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73626

CERTIFICATE OF DEATH.

129 D73626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1020 Sharp ST., 23 WARD)

2-FULL NAME Sophia B. Rice

(a) RESIDENCE NO. 1020 Sharp ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James N. Rice

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila (State or country) Pa

PARENTS

10 NAME OF FATHER Benj. Height

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Mary A Glass

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs Arthur Gregory (Address) 1020 Sharp St

15 FILED MAR 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/13/ 1922 to 3/9/23 19

that I last saw her alive on 3/9/23 19

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Hypertension

Chr. Diff. Nephritis

Chr. Bronchitis & Asthma

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis with terminal Bronchopneumonia 8½ days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Emanuel Levy M. D.

3/10 1923 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Mar 12 1923
20 UNDERTAKER	ADDRESS
Wm D. Tickner & Sons	N Y Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

1 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73627

CERTIFICATE OF DEATH.

90 D73627

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 N. Linwood St. 6 WARD)

2-FULL NAME Edward Nunn Krug

(a) RESIDENCE NO. 204 N Linwood St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha B. Krug

6 DATE OF BIRTH (month, day, and year) July 21, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Surveyor

(b) General nature of industry, business, or establishment in which employed (or employer) Port of Balto

(c) Name of employer Balto 086

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Henry Krug Jr

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Annie Kinnick

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Prob Judge N. Krug

(Address) 828 E. Preston St

15 MAR 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov ..... 1922, to Mar 9 ..... 1923.

that I last saw h— alive on Mar 8 ..... 1923.

and that death occurred, on the date stated above, at 8-a- m.

The CAUSE OF DEATH* was as follows:

Cardiac Dis - (Valvular)

(duration) 1 yrs. - mos - ds.

CONTRIBUTORY (Secondary) Anasarca

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Jno R O'Donovan, M. D.

, 19 (Address) 125 W Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Mar 11 1923
20 UNDERTAKER Wm J Keelne & Sons	ADDRESS Norfolk

Spec.—6-9-19—H. P. Co.—1000 Bks.

Nancy Devon ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73628

CERTIFICATE OF DEATH.

90 D73628

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital WARD)

2-FULL NAME Miss Nancy Devon

(a) RESIDENCE. No. 2117 Lough ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Uncertain 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
82		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Tom Devon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Redan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Francis P. Devon

(Address) 1116 Forrest St.

15 FILED MAR 11 1923 ROBERT R. KRAUSER Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to March 11, 1923, that I last saw her alive on March 10, 1923, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John J. Krager, M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Cathedral Cemetery Mar 13 1923

20 UNDERTAKER — ADDRESS

Chas F. Evans & Son 11 8th St Royal Oak

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D73629

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 11-002

D73629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. BELAIR ROAD & VALLEY VIEW AVE. GARDENVILLE (WARD) 26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ADDIE Z. COOK

(a) RESIDENCE No. REISTERSTOWN MD. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) NOV. 20 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) AT HOME

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) REISTERSTOWN MARYLAND

PARENTS

10 NAME OF FATHER HAZEL COOK

11 BIRTHPLACE OF FATHER (city or town) REISTERSTOWN (State or country) MARYLAND

12 MAIDEN NAME OF MOTHER MARIA L. STOCKSDALE

13 BIRTHPLACE OF MOTHER (city or town) REISTERSTOWN (State or country) MARYLAND

14 Informant JOHN COOK (Address) BELAIR ROAD & VALLEY VIEW AVE. RASPEBURG

15 MAR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MARCH 9 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8th 1923. to March 9th. 1923. that I last saw her alive on March 4th. 1923. and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav A. Dutt, M. D.

3/11. 1923 (Address) Overlea

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
AS BURY CEMETERY REISTERSTOWN. MD	MARCH 12 1923
20 UNDERTAKER Fredk Lassahn & Sons	ADDRESS FULLERTON. MD.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73630

CERTIFICATE OF DEATH.

101-89

D73630

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 425 S. Gilmor ST. 19 WARD)

2-FULL NAME Amanda E. Masinge

(a) RESIDENCE NO. 425 S. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 18-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butts Md

PARENTS

10 NAME OF FATHER John Masinge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mackum Buhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Butts Md

14 Informant Mrs Masinge

(Address) 1014 Patapsco Ave

15 MAR 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1923 to Mar 8, 1923

that I last saw him alive on Mar 8, 1923

and that death occurred, on the date stated above, at 4-60P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell, M. D.

Nov 10, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Mar. 12 1923

20 UNDERTAKER Josiah Syfer — ADDRESS 1600 W. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73631

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73631

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1434 Hanover ST. 23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Gibson

(a) RESIDENCE NO. 1434 Hanover ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Thos. Gibson

6 DATE OF BIRTH (month, day, and year): Apr. 2, 1862

7 AGE — Years: 60 — Months: 11 — Days: — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Patrick Mulligan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Jos. Gibson 1434 Hanover St.

15 Filed MAR. 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 - 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 8, 1923, that I last saw h. alive on March 7, 1923, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Paresis & Pneumonia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of, ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

3 D. 1923 (Address) 1 Mondawmin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — DATE OF BURIAL: March 24, 23

20 UNDERTAKER: Margaret D. Flynn — ADDRESS: 1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73632

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

100-001 D73632

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 N. Caroline ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline J. Hillegeist

(a) RESIDENCE. No. 1330 N. Caroline ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L. Hillegeist

6 DATE OF BIRTH (month, day, and year) Dec 29 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Stephen Decatur McCauley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Louisa Whiteford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles H. Hillegeist (Address) Chevy Chase Md.

15 FILED MAR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1921, to Mch 10, 1923, that I last saw her alive on Mch 9, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. poly arthritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Kinzey, M. D.

3/10, 1923 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 12 1923

20 UNDERTAKER Chas. D. Black ADDRESS 742 W. Fayette Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73633

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D73633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 S. Chester ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Wladkowski

(a) RESIDENCE NO. 519 S Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Joseph Wladkowski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Josephine Rozwicz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Joseph Wladkowski (Address) 519 S Chester St

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to March 11, 1923, that I last saw him alive on March 10, 1923 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Kelleberger M. D.

, 19 (Address) 1709 Alice Anne St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	March 12 1923

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Iova Boyer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73634

50

D73634

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hague Hospital

CITY OF BALTIMORE: (No. ..... ST., 25 WARD) +123

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Iova Boyer

(a) RESIDENCE No. 233 Broadway ST., ... WARD Hanover Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel E. Boyer

6 DATE OF BIRTH (month, day, and year) Dec 14 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	50	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Henry Wareheime

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susana Stanfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Holland Wareheime

(Address) 2516 Morton ave

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-11-1923

17 I HEREBY CERTIFY, That I attended deceased from 3-3, 1923, to 3-11, 1923, that I last saw h- alive on 3-11, 1923, and that death occurred, on the date stated above, at 10.25 p. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 3-6-23

Was there an autopsy? No Gall Stones c

What test confirmed diagnosis? Clinical findings

(Signed) Karl Stimmueller, M. D.

(Address) 327 N. Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover Pa — DATE OF BURIAL 3/13/23

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73635

CERTIFICATE OF DEATH.

101-001 D73635

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 70 WARD)

2-FULL NAME Edward F. Shea

(a) RESIDENCE NO. 2118 West Pratt St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 2d 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal Driver
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Not Known

14 Informant Mrs Edwin Eberts
(Address) 2122 Belmore Ave

15 MAR 12 1923 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 11, 1923.
that I last saw h[illegible] alive on March 11, 1923.
and that death occurred, on the date stated above, at 11.30 a.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? — Date of .....
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) Edward J. Kadenahn, M. D.
, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 3/14/23 19

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dorothea Gray.

D73636

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D73636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 758 W Mulberry St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothea Gray

(Residence in Baltimore: No. 758 W Mulberry St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	Col	Sgl

6-DATE OF BIRTH, Dec 29 1920
(Month) (Day) (Year)

7-AGE, 2 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER. John Gray

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Ida Gray

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Gray

(Address) 758 W Mulberry St

15 FILED MAR 12 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ topsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H K Jones M. D.
(Coroner.)

3-21 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	3-12 1923
20-UNDERTAKER.	ADDRESS 142
John H Soader	W Lee St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D73637

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

D73637

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 767 Raborg St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

2-FULL NAME Joseph Smith

(Residence in Baltimore: No. 767 Raborg St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Col	Married

6-DATE OF BIRTH ..... (Month) ..... (Day) 1878 (Year)

7-AGE 43 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE (State or country) Balto City

PARENTS

10-NAME OF FATHER Jas Smith

11-BIRTHPLACE OF FATHER (State or country) Va

12-MAIDEN NAME OF MOTHER Richard Saunders

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora Smith

(Address) 767 Raborg St.

15- MAR 12 1923 Filed ....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH March 11 (Month) (Day) 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1923, to, March 11 1923, that I saw h-- alive on March 10 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

3-11 1923. [Address] 117 W Saratoga

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Mt Auburn — DATE OF BURIAL 3-14 1923

20-UNDERTAKER John H. Soader — ADDRESS 143 N Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D73638

HEALTH DEPARTMENT—CITY OF BALTIMORE

57

D73638

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 925 N Eden ST., 10 WARD)

2-FULL NAME Julius Solomon

(a) RESIDENCE NO. 925 N Eden ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rubman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 180

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Hyman Solomon

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Esther Goldstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant H. Solomon
(Address) 925 N Eden st

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-1923

17 I HEREBY CERTIFY, That I attended deceased from 3/8, 1923, to March 11, 1923, that I last saw him alive on March 11, 1923, and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Ch. Diabetes

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of — — —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein M. D.

3/12, 1923 (Address) 733 Aisquith st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rising Sun

DATE OF BURIAL 3/12 1923

20 UNDERTAKER L. Levinson & Bro

ADDRESS 1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73639

CERTIFICATE OF DEATH.

100-001

D73639

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 N. Glover ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irma Nelson

(a) RESIDENCE NO. 626 N. Glover ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept. 18-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Raymond Nelson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Anderson

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Raymond Nelson (Address) 626 N. Glover St.

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 7, 1923, to March 10, 1923, that I last saw her alive on March 10, 1923, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Peritonitis

(duration) 5 mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Frank J. Ayd M. D.

March, 1923 (Address) 2065 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dorf Lawn Cem — DATE OF BURIAL: Mar 13 1923

20 UNDERTAKER: Geo M. Fair & Son — ADDRESS: 8 N Wood

Spec.—1-10-21—M&T—1500 Blks.

D73640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73640

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S Stricker ST., 18 WARD)

2-FULL NAME Jo Jan Buczek (BUCZET)

(a) RESIDENCE No. 1224 Hudson ST., 19 WARD

(Usual place of abode) 24 1/2

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24/22.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER James Buczek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bello. Md.

12 MAIDEN NAME OF MOTHER Cordia Otremba.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bello. Md.

14 Informant James Buczek. (Address) 1224 Hudson St.

15 FILED MAR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/23 19

17 I HEREBY CERTIFY, That I attended deceased from 3/1/23, 19, to 3/11/23, 19.

that I last saw ... alive on 3/8/23, 19,

and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? ... Not to my knowledge.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ... M. D.

3/13/23 19 (Address) 3011 Fountain

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Mar 12 1923.

20 UNDERTAKER M. F. Sadowski. ADDRESS 705 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73641

CERTIFICATE OF DEATH.

29 D73641

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 826 Tyson ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tye Stewart

(Residence in Baltimore: No. 826 Tyson St.; ....yrs.,....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Mar (Month) 10 (Day) 1922 (Year)

7-AGE, 1 yrs. 1 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Chas Stewart

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Co Md.

12-MAIDEN NAME OF MOTHER, Sarah Murray

13-BIRTHPLACE OF MOTHER (State or Country) Westminster Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Stewart

(Address) 826 Tyson St.

15- Filed MAR 12 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 5th 1923, to March 9th 1923, that I saw h im alive on March 9th 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Tetanus

(Duration) ....yrs. ....mos. 7 ....ds.

CONTRIBUTORY (Secondary) Abrasion on chest

(Duration) ....yrs. ....mos. 10 ....ds.

(Signed) Chas Sheiden M. D.

Mar 11th, 1923. (Address) 522 Baronmount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 3/12, 1923

20-UNDERTAKER Samuel Stensby

ADDRESS 578 Eddlett

D73642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 D73642

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 164 Dolphin St. St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Robinson

(Residence in Baltimore: No. 164 Dolphin St. St.: yrs., 2 mos. 25 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
Female	colored	single

6-DATE OF BIRTH, Feb. 14, 1902 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Wash. D.C

PARENTS.

10-NAME OF FATHER, Fred Robinson

11-BIRTHPLACE OF FATHER (State or Country). Unk.

12-MAIDEN NAME OF MOTHER Louise Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Wash. D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Robinson

(Address) 164 Dolphin St

15- Filed MAR 12 1923, 191.. ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kennedy M. D. (Coroner.)

March 11, 1923 (Address) 2803 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Washington D.C.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	3/14 1923
20-UNDERTAKER	ADDRESS
Samuel T. Hemsley	1138 Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73643

101-001

CERTIFICATE OF DEATH.

D73643

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sqr. Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... John A. Walmer

(a) Residence No. 4130 Wilkins Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 24-1907

7-AGE. 15 yrs. 9 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER. Morris H Walmer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Washington D.C.

12-MAIDEN NAME OF MOTHER. Gertrude L Hanzyt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Marshall Ill

11- (Informant) Morris H. Walmer

(Address) 4103 Wilkins Ave

15- Filed MAR 12 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 10. 23

17- I HEREBY CERTIFY, That I attended deceased from March 3 1923 to March 10 1923

that I last saw h.. alive on March 10 1923

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18- Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sign & Symptoms

(Signed) Walter A Lee M. D

3. 10. 1923 (Address) 541 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
LOUDON PARK	3/12 1923
20-UNDERTAKER ROBERT BROOKS & SON	ADDRESS Calhoun Hollins Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73644

CERTIFICATE OF DEATH.

80 D73644

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 Rock ST., 18 WARD)

2-FULL NAME. Walter M. Clark

(a) RESIDENCE NO. 209 Rock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Daniel Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lillian Chesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ethel Summers

(Address) 207 Rock St

15 FILED MAR 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8 1923

17

I HEREBY CERTIFY, That I attended deceased from Mch 5, 1923, to Mch 8, 1923,

that I last saw him alive on Mch 8, 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia ante

4 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Norwood, M. D.

Mch 9 1923 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 3-12 1923

20 UNDERTAKER Dunn & Eaton

ADDRESS 916 Park ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Did not know what was the cause

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73645

D73645

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 Pulmer St.; Alley 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph T Washington

(Residence in Baltimore: No. 1030 Pulmer St.; 11 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, 2 (Month) Mar. (Day), 1912 (Year)

7-AGE, 11 yrs. ..... mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS

10-NAME OF FATHER, Thomas Washington

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Moore

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Washington

(Address) 1030 Pulmer

15- Filed MAR 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 10 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 4 1923, to Mar 10 1923, that I saw h[illegible] alive on Mar 9 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William E Burton M. D.

Mar 18 1923 (Address) 162 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 3-14-, 1923

20-UNDERTAKER Daniel Easton

ADDRESS 916 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1560 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73646

CERTIFICATE OF DEATH.

31

D73646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Walnut Ave. Ward 17)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy E Williams

(a) RESIDENCE NO. 707 Walnut Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE: Years 36 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): Public Works

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Daniel Everton (Address) 916 Pearre Ave.

15 Filed MAR 12 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 6th, 1923, to March 9th, 1923, that I last saw h[illegible] alive on March 9th, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Slack, M. D.

3/11, 1923 (Address) 924 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 3-12 1923

20 UNDERTAKER: Dent Corby

ADDRESS 916 Pearre Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D73647

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D73647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2310 Jefferson St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gerkes

(a) Residence No. 2334 E. Jefferson St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Emma Gerkes

6-DATE OF BIRTH (month, day and year) Dec 25-1845

7-AGE 77 yrs. 2 mos. 18 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Needleworker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

11- (Informant) Frampis Prasal

(Address) 2310 E. Jefferson St

15- Filed MAR 12 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 9-1923

17- I HEREBY CERTIFY, That I attended deceased from Mar. 7 1923 to Mar. 9 1923

that I last saw h.. alive on Mar. 9 1923

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Vincent J. Cobb M. D.

, 19 (Address) 845 N. Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF REMOVAL Greenmount Cem. DATE OF BURIAL Mar. 12, 1923

20-UNDERTAKER Jas. C. Fuller ADDRESS 2334 E. Jefferson St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

William J. McCauley

D73648

HEALTH DEPARTMENT—CITY OF BALTIMORE

66

D73648

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 134 Belvedere St. 29 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John F. McCauley

(Residence in Baltimore: No. 134 Belvedere Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Widower

6 DATE OF BIRTH: Dec 1, 1881 (Month) (Day) (Year)

7 AGE: 41 yrs. 3 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Butchers
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10 NAME OF FATHER: John F. McCauley

11 BIRTHPLACE OF FATHER (State or Country): Md

12 MAIDEN NAME OF MOTHER: Susanna Phillips

13 BIRTHPLACE OF MOTHER (State or Country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George W. McCauley

(Address) 134 E Belvedere Ave

15 Filed MAR 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 10, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John F. Tourasse M. D. (Coroner.)

Mar 14, 1923 (Address) 1632 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: March 13th 1923

20 UNDERTAKER: Henry Lutz

ADDRESS 1203 N. Broadway

Spec.—1-10-21—M&T—1500 Blks.

D73649

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D73649

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Visitation Convent Park Ave & Centre St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Jane Frances Egan.

(a) RESIDENCE No. Visitation Convent Park Ave & Centre St. WARD.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Egan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Egan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Rev Mother M Aloysius Doonan Park Ave & Centre St.

15 FILED MAR 12 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10" 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 10, 1923, that I last saw h[e] alive on March 10, 1923, and that death occurred, on the date stated above, at 5.40 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles O'Donovan, M. D.

March, 1923 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	March 12 1923

20 UNDERTAKER Wm J Hartwell ADDRESS 2236 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73650

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST. 5 WARD)

2-FULL NAME Solomon Freidman

(a) RESIDENCE No. 115 ais gutth street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Freidman

6 DATE OF BIRTH (month, day, and year) 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ..... (Address) 1439 E Baltimore

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to March 11, 1923, that I last saw h[illegible] alive on March 11, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) senile

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Alfred Bandler, M. D.

3/13, 1923 (Address) 710 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Int. Carmel	March 12 1923

20 UNDERTAKER Jack Levin, ADDRESS 1439 E Baltimore

D73651 HEALTH DEPARTMENT—CITY OF BALTIMORE D73651

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Protestant Inf. St., 13 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. George Nuddy

(Residence in Baltimore: No. 837 Chauncey Ave St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	S

6-DATE OF BIRTH, Sept. (Month) ..... (Day) 1918 (Year)

7-AGE	If LESS than 1 day,
4 yrs. 6 mos. ds.	hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of Industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Jacob Nuddy

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Elizabeth Cohn

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nuddy

(Address) 837 Chauncey Ave.

MAR 12 1923

Filed ..... 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of pelvis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) automobile accident

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner)

March 16 1923 (Address) 2703 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 834 Chauncey Ave.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Westview Circle Mt. Carmel March 12 1923

20-UNDERTAKER Jacobs ADDRESS 1439 E. Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

D 73652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 73652

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1133 Cleveland St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Abram B. Frick

(a) Residence No. 1133 Cleveland St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Quinn

6-DATE OF BIRTH (month, day and year) Oct 22 1861

7-AGE. 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer). 015
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Abram Frick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Del

12-MAIDEN NAME OF MOTHER, Julia Hayne

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-(Informant) Mrs Jennie Frick

(Address) 1133 Cleveland St.

15-Filed 12 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 11 1923

17- I HEREBY CERTIFY, That I attended deceased from March 9, 1923 to March, 1923, that I last saw h.. alive on March 11, 1923 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion Delirium

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Clifford Dunn M. D.

, 19 (Address) 1133 Cleveland St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill DATE OF BURIAL. Nov 17, 1923

20-UNDERTAKER. Wm Cook ADDRESS 502 E Pratt

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Junius Gibson

D73653 HEALTH DEPARTMENT—CITY OF BALTIMORE 11-001 73653

73653

CERTIFICATE OF DEATH.

D73653

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Woodyear St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Junius Gibson

(a) RESIDENCE. No. 925 Woodyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred One yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
One	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary Gibson (Address) 925 Woodyear St.

15 MAR 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 26th, 1923, to March 10th, 1923, that I last saw him alive on March 5, 1923, and that death occurred, on the date stated above, at 7-0- m.

The CAUSE OF DEATH* was as follows:

Bronche Pneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. Trammell Fort, M. D.

, 19 (Address) 746 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mar. 12 1923
20 UNDERTAKER	ADDRESS 1303 Druid Hill
Charles H. Dennis	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73654

CERTIFICATE OF DEATH.

100-001

D73654

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 53 Darley av St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sherlay Fletcher

(Residence in Baltimore: No. 53 Darley av

St.; yrs., 3 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word)

6 DATE OF BIRTH: Nov 13, 1922 (Month) (Day) (Year)

7 AGE: yrs. 3 mos. 27 ds. If LESS than 1 day, hrs. or ndu.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE. (State or Country): Balto City Md

PARENTS.

10 NAME OF FATHER: Dewey H Fletcher

11 BIRTHPLACE OF FATHER (State or Country): Md

12 MAIDEN NAME OF MOTHER: Margie L Gosnell

13 BIRTHPLACE OF MOTHER (State or Country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dewey H Fletcher

(Address) 53 Darley av

15 Filed MAR 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 10, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to *his death on the day stated above.

The CAUSE OF DEATH* was as follows:

J. J. Donahue

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. H. Morrissey M. D.
(Crony)

Mar 12, 1923 (Address) 3672 Roland av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Mary's Home — DATE OF BURIAL: Mar 13 1923

20 UNDERTAKER: Cremmelt & Son — ADDRESS: Eastern av

Spec. 1-10-21—MAT—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73655

CERTIFICATE OF DEATH.

57 D73655

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Clifton St., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. P. Evans

(a) RESIDENCE NO. 1602 Clifton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: John E. Evans

6 DATE OF BIRTH (month, day, and year): March 9 1861

7 AGE: Years: 62 | Months: — | Days: — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Culvert Co. Md

PARENTS

10 NAME OF FATHER: Richard Gantt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Culvert Co. Md.

14 Informant: Mrs. S. V. Kalkman (Address) 1602 Clifton ave

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 1922 to Mar 9. 1923, that I last saw h/ alive on Mar 9, 1923 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

Probably

(duration) ... yrs ... mos ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell, M. D.

Mar 9, 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Mar 12 1923

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73656

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 N. Pulaski ST., 20 WARD)

2-FULL NAME George A. Gray

(a) RESIDENCE No. 429 N. Pulaski ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorotha Gray

6 DATE OF BIRTH (month, day, and year) March 24-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) House painting 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER James Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ellenor B. Greason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Dorotha Gray

(Address) 429 N. Pulaski St

15 MAR 1 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1923, to Mar 10, 1923, that I last saw him alive on Mar 10, 1923 and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (1 hour)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Walter E. Tuckerman, M. D.

Mar 10, 1923 (Address) 2002 N Lemington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cem	Mch 13 1923

20 UNDERTAKER Wm E. Black ADDRESS 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73657

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 Lanvale St.; Lanvale St. WARD)

REGISTERED NO. 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina A Gary

(a) RESIDENCE. No. 140 Lanvale St. Lanvale St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob L. Gary

6 DATE OF BIRTH (month, day, and year) April 4th 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Lohr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lucy F. Russell

(Address) 224 Fulton Ave

15 MAR 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1923, to Mar 8, 1923,

that I last saw h[illegible] alive on Mar 8, 1923.

And that death occurred, on the date stated above, at 10 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Encephalitis

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) [illegible] M. D.

3/9, 1923 (Address) 1729 N [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar 12 1923

20 UNDERTAKER F. B. Heppard ADDRESS 2236 Fred'k Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73658

CERTIFICATE OF DEATH.

31 D73658

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3500 Egerton Road St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Starr Ethete

(Residence in Baltimore: No. 3800 Egerton Road St.; 47 yrs. 4 mos. 27 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow of

6-DATE OF BIRTH, October 11, 1875
(Month) (Day) (Year)

7-AGE, 47 yrs. 4 mos. 27 da.

If LESS than 1 day, ...hrs. or.....mis.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Starr

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Ann E. Summit

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. A. Roberts

(Address) 3800 Egerton Road

15- MAR 12 1923, 191..... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from about 1914, to March 10 1923, that I saw h.. alive on March 10 1923, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 12 yrs. (Duration) .....yrs. .....mos. .....da.

CONTRIBUTORY (Secondary)

..... (Duration) .....yrs. .....mos. .....da.

(Signed) Wm. DeLoney Thomas M. D.

March 12, 1923 (Address) 3304 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cemetery

DATE OF BURIAL. Mar. 13 1923

20-UNDERTAKER Harry H. Amass

ADDRESS 4244 Ridgewood Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D73659

D73659

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Yeager

(a) RESIDENCE NO. 201½ S. Madeira ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ✓ mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26-1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 502

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER William A. Yeager

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Feldthuse

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Margaret Feldthuse
Address 201½ S. Madeira St.

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar
Filed ....., 19 ..... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to March 10, 1923, that I last saw h[im] alive on March 10, 19 23, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

Inanition

Intestinal Indigestion.

(duration) yrs. 12 mos ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Hosp(

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Moses Cellmer M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL March 12 1923

20 UNDERTAKER William G. Schaffer — ADDRESS 1816 Monument ST.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(William Grimes)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73660

CERTIFICATE OF DEATH.

118-002

D73660

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N. Pennsh ST., 16 WARD)

2-FULL NAME William Grimes

(a) RESIDENCE NO. 810 N. Pennsh ST., WARD .....

(Usual place of abode) dont (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept— 1873

7 AGE 49	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day labor 040

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Frank Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Thomas Grimes 810 N. Pennsh St.

15 MAR 1 2 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 9 - , 1923 , to Mar. 10 - , 1923 .

that I last saw him alive on Mar. 10 - , 1923 .

and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) - yrs. - mos. 2 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) - yrs. - mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Auburn Cem	3-13 1923

20 UNDERTAKER George T. A. Gibson ADDRESS 513 Lanvale

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73661 ✓ 185 D73661

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2021 E. Fayette Street ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Glassman

(a) RESIDENCE NO. 2021 E Fayette St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 19 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) 184

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Imkovs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 Ballast

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1923

17

I HEREBY CERTIFY, That I attended deceased from Mch. 6, 1923, to Mch 11, 1923, that I last saw ~~was~~ alive on Mch 11, 1923, and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows:

Potts fracture of R fort

(over)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj. M. Joppe, M. D.

Mch. 1923 (Address) 2026 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	3/12 1923

20 UNDERTAKER ADDRESS

Jack Levis 1439 E Ballast

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall at Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73662

CERTIFICATE OF DEATH.

129

D73662

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1834 N.Chapel St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Schneider

(Residence in Baltimore: No. 1834 N.Chapel St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	married

6-DATE OF BIRTH. Feb. 1865 1..... (Month) (Day) (Year)

7-AGE. 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country). England

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. A. Schneider

(Address) 1834 N.Chapel

15- Filed MAR 12 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10/23 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uraemia- Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Paul M. D. (Coroner)

3/12/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Park Cemetery	Mar 13 1923

20-UNDERTAKER.	ADDRESS
Wm Cook	502 E North Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73663

CERTIFICATE OF DEATH.

101-001 D73663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 E pratt ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Binder

(a) RESIDENCE NO. 1111 E Pratt ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? 32 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nail [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Binder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Meyer Binder (Address) New Cor Mass

15 Filed MAR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1923, to March 11th 1923, that I last saw him alive on March 11th 1923, and that death occurred, on the date stated above, at 8309 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

10

(duration) yrs. mos. 10 ds.

CONTRIBUTOR (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) M C Shikeras M. D.

3/14 1923 (Address) 2328 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Union Park	3/12 1923
20 UNDERTAKER	ADDRESS
A. Levinson & Bro	E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec. (10-23) 100 Bks.

D73864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73664

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2830 Clifton ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace Nickell

(a) RESIDENCE NO. 2830 Clifton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan 16/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER R. Wallace Nickell

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Edna G. Meagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant R. Wallace Nickell (Address) 2830 Clifton

15 MAR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to March 11, 1923, that I last saw him alive on March 10, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter R. Tublett, M. D.

3/14/23 19 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn. DATE OF BURIAL March 13 1923

20 UNDERTAKER Martin Bailey & Sons. ADDRESS 1827-29 North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73665

CERTIFICATE OF DEATH.

31 D73665

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Hurst. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis T. Tierney

(Residence in Baltimore: No. 1310 Hurst St. St.; ..... yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ..., 1888
(Month) (Day) (Year)

7-AGE. 35 yrs. ..... mos. ..... da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Shipping Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 109

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Walter Tierney

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Mary A. Grady

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Mary Tierney.....

(Address).....1310 Hurst St.....

15- MAR 12 1923

Yrs. ..... 191 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 28th 1922, to March 10th 1923, that I saw h[illegible] alive on March 10th 1923, and that death occurred, on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:

Intercurrent pneumonia

.....

.....

.....(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY Exhaustion
(Secondary)

.....(Duration) ..... yrs. ..... mos. ..... da.

(Signed) Lyman McCosker M. D.

March 12, 1923 (Address) 111 E Hamilton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Mar. 14., 1923.

20-UNDERTAKER Martin Fahey & Sons — ADDRESS 1822 W North ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73666 — CERTIFICATE OF DEATH. — D73666

1-PLACE OF DEATH — Brooklyn — REGISTERED NO. 101-001

CITY OF BALTIMORE: (No. 19 S. Second ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Frederick Zimmerman

(a) RESIDENCE NO. 19 S. Second ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of / WIFE of Caroline Zimmerman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S. Ind. Chemical Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George Zimmerman (Address) Brooklyn Md

15 MAR 1 2 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to March 10, 1923.

That I last saw h alive on March 9, 1923;

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Brooke M. D.

, 1923 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL 3/17/1923

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73667

D73667

CERTIFICATE OF DEATH.

Registered No. 161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Turner

(a) Residence No. 1510 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 7 '23

7-AGE. yrs. mos. 3 ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Harry Turner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Boston Mass.

12-MAIDEN NAME OF MOTHER, Mary Mahoney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant)

(Address)

15- Filed MAR 12 1923 19?

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 10 '23

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 19 23 to Nov 10 19 23

that I last saw h... alive on Nov 10 19 23

and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Signs & Sym

(Signed) H. J. Seragne M. D.

, 19 (Address) H. J. Seragne.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, Mar 12, 19 23

20-UNDERTAKER.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

162068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73668

CERTIFICATE OF DEATH.

100-001

D73668

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. ..... ST., 17 WARD)

2-FULL NAME Elizabeth Dorsey

(a) RESIDENCE NO. 337 W. Biddle St. City ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) March 31, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 7, 1923, that I last saw her alive on March 7, 1923, and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 9 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Mar 11 1923

20 UNDERTAKER Commissioner Health.

ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73669

CERTIFICATE OF DEATH.

100-001 D73669

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women's Home ST., 19 WARD)

2-FULL NAME Bella A. Griffiths

(a) RESIDENCE NO. 1400 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 24 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert County
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Griffis

11 BIRTHPLACE OF FATHER (city or town) Calvert Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Dorsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Ella J. Jones
(Address) Aged Women's Home

15 Filed , 19 Registrar

Robert P. Garrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 5, 1923, to Mch 10, 1923, that I last saw h... alive on March 10, 1923 and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

I Broncho Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Mch 11 1923 (Address) 939 or Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Mar 13 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MAR 12 1923

Spec.—1-10-21—M&T—1500 Blks.

D73670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73670

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 N. Lexington ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Sanders

(a) RESIDENCE NO. 1312 N. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9. 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	86	5	1.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward J. Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura A. Sanders

(Address) 1312 N. Lexington St.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MAR 12 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17

I HEREBY CERTIFY, That I attended deceased from February 28, 1923, to March, 1923,

that I last saw her alive on , 1923,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. L. Goldwater, M. D.

3/12, 1923 (Address) 21 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	March 12 1923
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 N. Fulton Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D73671

CERTIFICATE OF DEATH

100-001 D73671

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 509 Arlington Ave. ST.; 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Fallon

(Residence in Baltimore: No. 509 Arlington Ave. St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Sing

6-DATE OF BIRTH: 2 (Month) 20 (Day), 1923 (Year)

7-AGE: — yrs. — mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore City

PARENTS

10-NAME OF FATHER: James E. Fallon

11-BIRTHPLACE OF FATHER (State or country): W. Va

12-MAIDEN NAME OF MOTHER: Gertrude Miller

13-BIRTHPLACE OF MOTHER (State or country): Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James A. Fallon

(Address) 509 Arlington Ave

15. Filed ..... 191 Robert P. Harrison, REGISTRAR

Burial Permit Clerk.

MAR 12 1923

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 3 (Month) 11 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/10, 1923, to 2/10, 192[illegible]

that I saw him alive on 2/10, 192[illegible]

and that death occurred, on the date stated above, at 8 15a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 30 hrs

Contributory (SECONDARY) Coryza

(Duration) ..... yrs. ..... mos. 7 ds

(Signed) Wm Corning M. D.

3/11, 1923 (Address) 2100 E Fairmount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross

DATE OF BURIAL: 3/13, 192[illegible]

20-UNDERTAKER: Wm Cook

ADDRESS: 502 E Nor[illegible]

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73672

D73672

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1705 E 28th St., 9 Ward)

2-FULL NAME Elizabeth C Rogge

(a) RESIDENCE NO. 1705 E 28th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard A Rogge

6 DATE OF BIRTH (month, day, and year) Jan 24-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) Wife 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Edward O'Keefe

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Sarah Crogan

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant (Address) Gertrude Peterson 1705 E 28th St

Filed 3 12 1923 Robert P. Harrison, M. D. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-31, 1922, to 3/11, 1923.

That I last saw h[illegible] alive on 3/11, 1923.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Hemorrhage - exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) Dr Bernard Wise, M. D.

3/12 1923 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Mar. 14 1923

20 UNDERTAKER J. C. Windyard — ADDRESS 914 Fremont Ave

R.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73673

CERTIFICATE OF DEATH.

31

D73673

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Madison Ave. ST., 14 WARD)

2-FULL NAME PRESTON LITTLE

(a) RESIDENCE NO. 1623 MADISON AVE. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 22" 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hackettstown
(State or country) N. J.

PARENTS

10 NAME OF FATHER John S. Little

11 BIRTHPLACE OF FATHER (city or town) Hackettstown
(State or country) N. J.

12 MAIDEN NAME OF MOTHER Elizabeth A. Doren

13 BIRTHPLACE OF MOTHER (city or town) Hackettstown
(State or country) N. J.

14 Informant Mr. Nelson Knapp
(Address) 555 Main St. East Orange N.J.

15 Filed MAR 12 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12 1923

17 I HEREBY CERTIFY, That I attended deceased from SEPT. 1922, to MARCH 11 1923.

that I last saw h[illegible] alive on MARCH 11 1923.

and that death occurred, on the date stated above, at 5.00 A m.

The CAUSE OF DEATH* was as follows:

PULM. TUBERCULOSIS

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? BACTERIOLOGICAL EXAM.

(Signed) John L. Dorsey M. D.

3/12 1923 (Address) 1008 Catherine St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL East Orange N.J.

DATE OF BURIAL Mch. 15 1923

20 UNDERTAKER Jos. B. Cook

ADDRESS Jos. B. Cook Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 2t—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73674

CERTIFICATE OF DEATH.

100-001

D73674

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Light ST., 23 WARD)

2-FULL NAME Emma L Gayle

(a) RESIDENCE NO. 1824 Light ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C Gayle

6 DATE OF BIRTH (month, day, and year) April 20 1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) King & Queen Co Virginia

PARENTS

10 NAME OF FATHER George Tucker

11 BIRTHPLACE OF FATHER (city or town) King & Queen Co (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliza Mayo

13 BIRTHPLACE OF MOTHER (city or town) King & Queen Co (State or country) Virginia

14 Informant Mrs Annie M Garden
(Address) 1824 Light St

15 Robert F. Harrison, Registrar
Burial Permit Clerk.

MAR 12 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1923 to March 10, 1923, that I last saw him alive on March 9, 1923, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ... mos. 14 ds. 4

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Unnecessary

(Signed) ..... M. D.

..., 19... (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Point Va — DATE OF BURIAL March 12 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73675

CERTIFICATE OF DEATH.

91-002 D73675

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 E. Lanvale ST.; 12 WARD)

2-FULL NAME Mrs Bridget Flaherty

(a) RESIDENCE. NO. 414 E. Lanvale ST., 12 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Flaherty

6 DATE OF BIRTH (month, day, and year) Jan 9-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —0—

9 BIRTHPLACE (city or town) (State or country) County Cavan Ireland

PARENTS

10 NAME OF FATHER John McGuing

11 BIRTHPLACE OF FATHER (city or town) (State or country) County Cavan Ireland

12 MAIDEN NAME OF MOTHER Margaret McGovern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) County Cavan Ireland

14 Informant John F. Flaherty (Address) 414 E. Lanvale

15 Filed Mar 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1923, to March 10th, 1923, that I last saw h.. alive on March 9th, 1923, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Old age
Arterio Sclerosis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald A. Conry, M. D.

3-12, 1923 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic	March 12

20 UNDERTAKER Thomas Kelly & Son ADDRESS 422 W Mulberry

MAR 12 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73676

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE. (No. 36 N Lakewood Ave St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Maria C Dausch

(a) Residence No. 36 N Lakewood Ave St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 14yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 6-1908

7-AGE. 14 yrs. 9 mos. 6 ds. LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Joseph J. Dausch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Clara J Fuller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

11- (Informant) Joseph J Dausch

(Address) 36 N Lakewood Ave

15- Filed 19.. Robert P. Harrison, Registrar.

MAR 12 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 12/23

17- I HEREBY CERTIFY, That I attended deceased from Mar 11 1923 to Mar 12 1923

that I last saw h.. alive on Mar 12 1923

and that death occurred, on the date stated above, at 12 20 A. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Scarlet Fever

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sym

(Signed) Wm B Lemmon M. D

3/12, 1923 (Address) 718 N Pat Pk Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem

DATE OF BURIAL. Mar 13 1923

20-UNDERTAKER. Jas C Fuller

ADDRESS 2330 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73677

CERTIFICATE OF DEATH.

156

D73677

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 N. Monroe ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira Hutchins

(a) RESIDENCE NO. 625 Rosedale st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Mulatto	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late William H. Hutchins

6 DATE OF BIRTH (month, day, and year) Sept 7. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or.....min.
	72	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Eliza Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mr. Frank L. Hutchins (Address) 625 Rosedale st

15 MAR 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1923, to March 10, 1923, that I last saw he alive on Mch 10, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Infectious Arthritis

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. Steinbach, M. D.

, 19 (Address) Westworth apts,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL March 13 1923

20 UNDERTAKER Jos Joerdens & Son

ADDRESS 217 S. Paca

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73678 HEALTH DEPARTMENT—CITY OF BALTIMORE D73678

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma M. Mayhugh

(Residence in Baltimore: No. 1130 S. East Ave. St.) 3 yrs., 4 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	Single

6-DATE OF BIRTH. Oct. 15, 1919
(Month) (Day) (Year)

7-AGE. 3 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Melvin Mayhugh

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Hattie Kelly

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Melvin Mayhugh

(Address) 1130 S. East Ave.

15- Robert P. Harrison, ...192.....

Burial Permit Clerk. Registrar.

CR 127923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 12/23, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia-Scarlatinia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. E. Hollar M. D.
(Coroner.)

3/12/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Lawn	Mar 13th 1923
20-UNDERTAKER. Phelps & Lewis	ADDRESS 2016 Eutaw St.

(1) Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D73679 HEALTH DEPARTMENT—CITY OF BALTIMORE D73679

CERTIFICATE OF DEATH.

202

1-PLACE OF DEATH U.S. Ordinance Department, Curtis Bay A.A.Co. Md.
Pronounced dead City of BALTIMORE: (No. South Baltimore General Hospital Ward)

Registered No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Haley.

(Residence in Baltimore: No. 2622 E. Preston St. St.; yrs. 51 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. ..... 1..... (Month) (Day) (Year)

7-AGE. 51 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Boiler-maker.
(b) General nature of industry, business, or establishment in which employed (or employer) 86

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Patrick Haley.

11-BIRTHPLACE OF FATHER, (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Mary Ann Roach.

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E. Haley. (brother)

(Address) 2622 E. Preston St.

15- Robert P. Harrison, 192 Registrar.
Burial Permit Clerk.

APR 12 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 9th. 1923. 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said decessed came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
struck on the head by the
accidental fall of a stack.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Feb. 12, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	3/13/ 1923
20-UNDERTAKER.	ADDRESS 3000
J. A. Doran	E. Baltimore.

NOTICE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Alice Bradley Ilsley)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73680 X 46 D73680

CERTIFICATE OF DEATH.

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST.: Alice B. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Spencer Ilsley.

(a) RESIDENCE. No. 428 Jefferson ST., WARD. Milwaukee, Wis.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Spencer Ilsley

6 DATE OF BIRTH (month, day, and year) Aug 5 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Milwaukee
(State or country) Wis.

PARENTS

10 NAME OF FATHER Edw. Bradley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ma.

12 MAIDEN NAME OF MOTHER Celia M Hall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wis.

14 Informant Hatty M. Crunden
(Address) St Louis. Mo.

15 Filed 12 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1917, to March 12, 1923, that I last saw h.. alive on March 12, 1923, and that death occurred, on the date stated above, at 11 20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of recto-vaginal septum.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis? Biopsy

(Signed) Robert E. Preece, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Milwaukee Wis.	3/18 1923
20 UNDERTAKER	ADDRESS
Chas B. Black	741 W. North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73681

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST., 12 WARD)

2-FULL NAME Laura Elizabeth Williamson

(a) RESIDENCE NO. Home for Incurables ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert A. Williamson Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER James Miller

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Rusk

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Orson F. Williamson (Address) 3320 Hayward Ave

15 MAR 13 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1923 to March 10, 1923.

that I last saw her alive on March 10, 1923.

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Arcs Pulmonary

Chronic passive Congestion

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) — yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm Hinkey M. D.

3/12 1923 (Address) Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	3/14/23
20 UNDERTAKER	ADDRESS
Mrs Addie M. Walker	723 N. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Heel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73682

CERTIFICATE OF DEATH.

185 D73682

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Forest Park Ave ST., Sanatorium WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite Sophia Hackett

(a) RESIDENCE NO. 1716 E. 33rd ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 89 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? 39 yrs. 8 mos. 17 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Joseph Hackett

6 DATE OF BIRTH (month, day, and year): January 1st 1834

7 AGE: Years 89 Months 8 Days 17 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: ——
(b) General nature of industry, business, or establishment in which employed (or employer): ——
(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Hanover Germany

PARENTS
10 NAME OF FATHER: Wm Buchmann
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Margaretha Jennewein
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Geo. L. Frederick
(Address): 1716 E. 33rd St

15 Filed MAR 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 10 1923

17
I HEREBY CERTIFY, That I attended deceased from Oct. 1922, to March 10, 1923,
that I last saw her alive on March 10, 1923,
and that death occurred, on the date stated above, at 3.30 P. m.
The CAUSE OF DEATH* was as follows:
Senile Dementia
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Fractured Left Hip.
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto Md
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? The above
(Signed) Marshall B Hurst M. D.
(Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL 1923

20 UNDERTAKER: H B Heffner — ADDRESS 2256 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1921—M&T—1500 Blks.

Dr. McCleary-Payson Co
Rev. Lotz
Mrs Downes

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73683

D73683 REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2120 Fyle ST. 20 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Haupt.

(a) RESIDENCE NO. 2120 Fyle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Haupt.

6 DATE OF BIRTH (month, day, and year): Aug 13 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10 NAME OF FATHER: Geo. Staeg
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Elizabeth Grabel
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Margaret Delunt 1813 Lemmon St

15 MAR 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 11 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 11, 1923.
that I last saw alive on March 11, 1923
and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Edema.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Benj Oh McCleary, M. D.
(Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Mar 26 19

20 UNDERTAKER: J. B. Wayland 2136 — ADDRESS: Fulton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73684

CERTIFICATE OF DEATH.

× 117

D73684

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W. Agnes Hospital ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Margaret McGovern.

(a) RESIDENCE No. St Josephs Home Emmitsburg ST., WARD Emmitsburg Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: None

165

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: Bernard McGovern.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Margaret Wallace.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant: Sister Mary Clare
(Address) St Agnes Hosp.

15 Filed MAR 13 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1923

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to March 12, 1923, that I last saw her alive on March 12, 1923, and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

acute Appendicitis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Mar. 10, 1923

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edward A. Kitlowski, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmitsburg Md

DATE OF BURIAL: March 22

20 UNDERTAKER: Martin Fahey & Son

ADDRESS: 1827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imprtant. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73685

CERTIFICATE OF DEATH.

100-001 D73685

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2317 Guilford Ave. ST., 12 WARD)

2-FULL NAME Virginia Underwood

(a) RESIDENCE NO. 2317 Guilford Ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 89 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A. Underwood

6 DATE OF BIRTH (month, day, and year) Dec. 18, 1833

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
89	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel R. Kirby

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellener Hunter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Howell H. Lorman
(Address) 2317 Guilford Ave.

15 Filed MAR 13 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1918, to Mar. 11, 1923.

that I last saw h[illegible] alive on Mar. 10, 1923.

and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Kerr, M. D.

3-12, 1923 (Address) 5200 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: March. 14 1923

20 UNDERTAKER: Wm. C. Black, ADDRESS: 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73686

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 237 St. Dallas St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ransom

(Residence in Baltimore: No. 236 So. Dallas St St.; yrs. 20 mos. ds.)

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Widow

6-DATE OF BIRTH Unknown (Month) (Day) (Year)

7-AGE. About 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 070

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept Eastern Dist

(Address).....

15- MAR 13 1923 ROBERT P. KRAUTER,
Filed ..... 192 . Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March 9th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained thereat and (Inquest, Autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Asthma

(Duration) yrs. mos. ds.

(Signed) Jno. B. Horton M. D.
Coroner.

March 12 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Natural

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel	3/13/1923

20-UNDERTAKER.	ADDRESS
John W Henderson	1502 E Monument

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73687

CERTIFICATE OF DEATH.

129 ✓ D73687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S. Regester ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bamberger

(a) RESIDENCE NO. 417 S. Regester ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 21st 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Bamberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Josephine Slitzer sister (Address) 417 S. Regester St

15 MAR 13 1923, 19 ROBERT M. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1923, to March 9, 1923, that I last saw her alive on March 6, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Par. Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Disease (Valvular)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. L. Heller, M. D.

3/12/1923 (Address) 408 St Paul Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. | DATE OF BURIAL March 13 1923

20 UNDERTAKER Lilly + Zeller | ADDRESS 458 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73688

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 N° Kin ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evans Ennis

(a) RESIDENCE. NO. 836 Mc Kim ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	widower / widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Ida Shaw
(Address) 826 Biddle St

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 11, 1923, that I last saw h[e] alive on March 11, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Dilitation of Heart

30 minutes (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

3/11. 1923 (Address) 1612 E Monument 3

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Mar 14 23

20 UNDERTAKER Chas. H. Johnson ADDRESS 46 N Caroline St.

N. B.—WHILE LEARNED BY INQUIRY, ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73689

CERTIFICATE OF DEATH.

5 91-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 523 N Eden (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Johnson

(a) RESIDENCE. No. 523 N Eden St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aa co md

PARENTS

10 NAME OF FATHER Jacob Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Sarah Johnson
(Address) 523 N Eden St

15 Filed , 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1923, to Mar 11, 1923

that I last saw h.. alive on Mar 10, 1923

and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fiske, M. D.

3/11 1923 (Address) 612 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Cem	Mar. 15 1923

20 UNDERTAKER Chas. H. Johnson

ADDRESS 467 N Caroline St

APR 3 1923

MAR 13 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. PHYSICIANS should state mation should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73690

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 E Lefington ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jackson

(a) RESIDENCE NO. 1102 E Lefington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 53; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimd.

PARENTS

10 NAME OF FATHER: Samuel Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimd.

12 MAIDEN NAME OF MOTHER: Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: J. C. Jackson

(Address): 529 E Monument St

15 Filed MAR 13 1923 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/10/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/10/ , 1923, to 3/10/ , 1923, that I last saw h[illegible] alive on 3/10/23, 1923, and that death occurred, on the date stated above, at 9:45 P.m.

The CAUSE OF DEATH* was as follows: Acute Pancreatitis

(duration) yrs. mos 1 ds

CONTRIBUTORY (Secondary): Mitral regurgitation

(duration) yrs. mos.? ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson M. D.

(Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — DATE OF BURIAL: Mar 13 19 23

20 UNDERTAKER: Chris. L. Johnson — ADDRESS: 467 N. Caroline St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73691

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802-N-Calvert-St. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM FRANCIS BEVAN

(a) RESIDENCE NO. 1802-N-Calvert-St. ST., 12 WARD (Resident)
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? 66 yrs. 1 mos. 7 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Dickerson Poole

6 DATE OF BIRTH (month, day, and year) Feby-4-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Estimator

(b) General nature of industry, business, or establishment in which employed (or employer) Interior Decorating

(c) Name of employer Roman Tile Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles F. Bevan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Carback

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant William F. Bevan Jr., (Son)
(Address) 1101-N-Calvert-St., City

15 Filed MAR 12 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11- 1923

17 I HEREBY CERTIFY, That I attended, deceased from Mar 9th, 1923, to Mar 11th, 1923.

that I last saw h[illegible] alive on Mar 11th, 1923.

and that death occurred, on the date stated above, at 2 45 Pm.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia -

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) hypostatic with acute Cardiac Dilitation (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Robert C. Whitehead, M. D.

3/11, 1923 (Address) 1111 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL GREENMOUNT CEMETERY — DATE OF BURIAL March-13-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
mation should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified. E.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73692

CERTIFICATE OF DEATH.

D73692

164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #2127-St.Paul-St. ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY BUSBY

(a) RESIDENCE NO. #2127-St.Paul-St. ST., 12 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Feby-13-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Tyrone Co., Ireland

PARENTS

10 NAME OF FATHER Robert Busby

11 BIRTHPLACE OF FATHER (city or town) Tyrone Co. (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) Tyrone Co. (State or country) Ireland

14 Informant Chas.H.Boyd,(cousin)
(Address) 2127-St.Paul-St., City

15 Filed ....., 19.... ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MAR 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 3, 1923, to March 11, 1923, that I last saw her alive on Mch 11, 1923, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Asthenia and Dementia, Senilis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Increasing Asthenia & hypostatic Pneumonia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Robert W. Mefflein, M. D.

3/12. 1923 (Address) No 1076 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREENMOUNT CEMETERY — DATE OF BURIAL: March-13-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W.NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

D73693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73693

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3640 Roland ave ST. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary K. Scholtz

(Residence in Baltimore: No. 10 Dellwinsville Rd St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. Female

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6 DATE OF BIRTH March 4, 1857 (Month) (Day) (Year)

7 AGE. 66 yrs. mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE. (State or Country) Balto Md

PARENTS.

10 NAME OF FATHER Geo Standiford

11 BIRTHPLACE OF FATHER (State or Country) Bedad Md.

12 MAIDEN NAME OF MOTHER Katherine Garner

13 BIRTHPLACE OF MOTHER (State or Country) Belair

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Scholtz

(Address) Dempsinville Rd

15 Filed MAR 13 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 11, 192[illegible] (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and from [illegible] find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis
of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

(Address) 3632 Roland ave

Mar 13, 1923

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Dempsinville Md

19 PLACE OF BURIAL Geo Co Md

DATE OF BURIAL March 14 1923

20 UNDERTAKER E A Wedefeld

ADDRESS 501 E Lexington St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73694

CERTIFICATE OF DEATH.

9 ✓ D73694

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Monroe ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H. Botcher

(a) RESIDENCE NO. 119 S. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S-C

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/20/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Geo. P. Botcher

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Christina Hartman

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant George P. Botcher
(Address) 119 S. Monroe St

15 MAR 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/23 19

17 I HEREBY CERTIFY, That I attended deceased from 3/10/23, 19, to 3/12/23, 19,
that I last saw him alive on 3/12/23, 19,
and that death occurred, on the date stated above, at 12:10 m.
The CAUSE OF DEATH* was as follows:

Pertussis

(duration) Thirty days mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Probable)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Bernard L. Seng, M. D.

3/13 1923 (Address) 1.5 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. McCulloh M.E. Church — DATE OF BURIAL Mch 15 1923

20 UNDERTAKER Elk Ridge Co-operative — ADDRESS 1532 Hollins St

George J. Smith

NOTE.—Every item should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73695

V59-003 D73695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 528 N. Pulaski St. 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Loretta Doyle

(a) RESIDENCE. No. 528 N. Pulaski St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. 6 mos. 6 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Feb 1 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward F Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Pazano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edward F. Doyle.
(Address) 528 N Pulaski St

15 MAR 13 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to March 12, 1923, that I last saw h[illegible] alive on March 12, 1923, and that death occurred, on the date stated above, at 5 a.m. The CAUSE OF DEATH* was as follows:

Spina - Bifida
(Dorsal Spine - Congenital) (duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Malformation (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Volentine M. D.
1923 (Address) 14 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 3/14/23 19

20 UNDERTAKER: Chas. F. Evans & Son

ADDRESS 1810 W. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73696 REGISTERED No. C D73696

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 S. Seventh St. ST.; 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry C. Parsons

(Residence in Baltimore: No. 908 S. Seventh St. St. 8m yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, October 24, 1851
(Month) (Day) (Year)

7-AGE, 31 yrs. 4 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): Penn. R.R. Co.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Harry Parsons

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Henritta Callender

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carolina A. Parsons

(Address) 908 S. Seventh St (Wife)

15-MAR 13 1923 Filed, 191 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1923, to March 11 1923, that I saw h[illegible] alive on March 11 1923, and that death occurred, on the date stated above, at 1.05 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Farrell M. D.

3/12/1923 (Address) 633-5-34

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem. DATE OF BURIAL, March 14, 1923

20-UNDERTAKER Tilly & Zuber ADDRESS 403 S. Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73697

CERTIFICATE OF DEATH.

74-001

D73697

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 Somerset ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bennett

(a) RESIDENCE NO. 420 Somerset ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Bennett

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
69				

8 OCCUPATION OF DECEASED Labor

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 440

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah Bennett

(Address) 420 Somerset St

15 MAR 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1923. to March 11, 1923.

that I last saw he/she alive on March 11, 1923.

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Palpitations of Heart

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Palpitations of Heart & Nervous Breakdown (duration) yrs. 2 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. F. W. Kennard M. D.

3-12 1923 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL national cemetery

DATE OF BURIAL March 14 1923

20 UNDERTAKER Edward Bryan

ADDRESS 631 orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73698 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73698

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Orleans ST.; 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Randall

(a) RESIDENCE. No. 1301 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Randall

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Co. Md

PARENTS

10 NAME OF FATHER Dennis Tolson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Kate Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Tolson (Address) 1301 Orleans St

15 MAR 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 11, 1923, to Mar 12, 1923, that I last saw h[illegible] alive on Mar 12, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

(Address) 120 Cassguiles St. 3-12-1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	March 14 1923
20 UNDERTAKER	ADDRESS 1631 Orleans
Edward Bryon	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73699

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D73699

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 927 Hanover Street. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Shana Gerstein.

(Residence in Baltimore: No. 927 Hanover St. St.; yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	White.	Married

6-DATE OF BIRTH. Do not know. (Month) (Day) 1..... (Year)

7-AGE. 58 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Russia.

PARENTS.

10-NAME OF FATHER. Hyman Zelic.

11-BIRTHPLACE OF FATHER. (State or Country). Russia.

12-MAIDEN NAME OF MOTHER. Asna Cantoravich.

13-BIRTHPLACE OF MOTHER. (State or Country). Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Zundel Gerstein. (husband)

(Address) 927 Hanover St.

15- MAR 13 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
Acute dilatation of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M.D.
(Coroner)

March 13 1923. (Address) 1917 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Lebanon Cem. DATE OF BURIAL. Mar 13 1923

20-UNDERTAKER. Jacob Lewis ADDRESS. 1439 E Pratt

R. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73700

CERTIFICATE OF DEATH.

129 D73700

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Harrison

(a) RESIDENCE NO. 1026 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Abraham Harrison

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Bechie Harris

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Simon Harrison
(Address) 1026 E Lombard St

15 Filed MAR 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923 to March 13, 1923.

that I last saw h alive on March 13, 1923

and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis Emphysema; Chr. Nephritis Hypertension

(duration) many yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Isidor L. Jury, M.D.

(Address) 3/13, 1923 Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest

DATE OF BURIAL 3/13 1923

20 UNDERTAKER D. Levinson & Bro

ADDRESS 1127 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE in YEARS, MONTHS and DAYS. If LESS than 1 day, HOURS or MINUTES. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D73701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73701

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 11 N Duncan ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A Albert

(Residence in Baltimore: No. 11 N Duncan St.; 30 yrs., 7 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 25, 1892 (Month) (Day) (Year)

7-AGE, 30 yrs. 7 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Brass
(b) General nature of industry, business, or establishment in which employed (or employer)..... Polisher

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, August A Albert

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Anna Etzel

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Carrie Albert

(Address) 11 N Duncan St

15- Filed MAR 13 1923 ROBERT R. KRAUTER 191. Burial Permit Clerk..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 10, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 9 1923, to March 10 1923, that I saw him alive on March 10 1923, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration).....yrs.....mos. 10 ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) A W Broadbeck M. D.

March 12 1923 (Address) Baltimore Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, I St Leonard

DATE OF BURIAL, Mar. 14., 1923

20-UNDERTAKER Peter Nicolaus

ADDRESS 2060 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73702

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 16 ST., ... WARD)

2-FULL NAME Richard M. Tyrrell

(a) RESIDENCE NO. 1012 W. Fenton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie Tyrrell

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 78 Months ..... Days ..... If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant: Frank Wright

(Address) Wash. D.C.

15 Filed MAR 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1923, to March 13, 1923,

that I last saw he alive on March 13, 1923,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. N. Wilkerson, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington DC — DATE OF BURIAL: Mar 13 1923

20 UNDERTAKER: W W Deal — ADDRESS: Wash. DC

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73703

CERTIFICATE OF DEATH.

X 18 22

D73703

Registered No. C.....

1-PLACE OF DEATH Westland Wharf Lancaster Co. Va.

City of BALTIMORE: (No. Brought to Pier #2 Light St. Wharf. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert White.(C).

(Residence in Baltimore: No. Leedstown, Va. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. Do not know. (Month) (Day) 1..... (Year)

7-AGE.			If LESS than 1 day,
22 yrs.	mos.	ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Deck hand
(b) General nature of industry, business, or establishment in which employed (or employer): Stm. Middlesex.

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER. Robert White.(C).

11-BIRTHPLACE OF FATHER. (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER. (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A.H.Seth.

(Address) Pier #2 Light St. Wharf.

15- FILED MAR 13 1923. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12, 1923. (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from the wharf at Westland Rappahannock River Lancaster Co. Va.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

March 13 192 3 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence. Leedstown Va

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Leedstown Va.	March 13 1923

20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73810 D73704 HEALTH DEPARTMENT—CITY OF BALTIMORE D73704

CERTIFICATE OF DEATH. X 118-00

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Wall

(a) RESIDENCE NO. Morgantown ST. W. Va. WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 20 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

should be stated EXACTLY. PHYSICIANS should state may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Chester L. Wall.

6 DATE OF BIRTH (month, day, and year): Jan. 7-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER: Nelson Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Virginia Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Robert B. Harrison, Burial Permit Clerk.

APR 13 1923 .19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21st, 1923, to March 13, 1923, that I last saw her alive on March 13, 1923 and that death occurred, on the date stated above, at 1.32 P. m.

The CAUSE OF DEATH* was as follows:

P.A. operation intestinal obstruction

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) operation ( ) ... duration) ... yrs. ... mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 28. 23

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) ... M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morgantown W Va

DATE OF BURIAL: March 18 1923

20 UNDERTAKER: Henry Jenkins & Son

ADDRESS: Orchard & Collord

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73705 D73705

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 214 Goodwood R St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Blume

(Residence in Baltimore: No. 214 Goodwood R St.; 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH. Sept. 6, 1846 (Month) (Day) (Year)

7-AGE. 77 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cornet Maker
(b) General nature of industry, business, or establishment in which employed (or employer). Musical Instruments

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H. B. Boyd

(Address) 214 Goodwood Rd Hamilton

15-

Filed Mar 13 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 12, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 12 1922 to Mar 12 1923 that I saw h~~e~~ alive on Mar 2 1923, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Hypertension

Form of Heart Disease

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer

(Duration) yrs. mos. ds.

(Signed) Chas L. Tilghman M. D.

3/13 1923 (Address) 2724 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, March 15, 1923

20-UNDERTAKER Robt L Little ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Settle 2435 Md Ave

Spec.—1-10-21—M&T—1500 Bks.

D73706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2419 Maryland Ave ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Garratt

(a) RESIDENCE No. 2419 Maryland Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice T. Garratt

6 DATE OF BIRTH (month, day, and year) May 1 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer Metropolitan Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Garratt

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales, Great Britain

14 Informant Alice T. Garratt
(Address) 2419 Maryland Ave.

15 Filed ....., 19..... Robert F. Harrison, Registrar

R 13 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to March 12, 1923, that I last saw h alive on March 11, 1923, and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Cardio vascular Hypertension

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas H. Settle, M. D.

3/14, 1923 (Address) 2435 Md Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	March 16 1923
20 UNDERTAKER	ADDRESS
A. Sander Sons	1710 Pennsylvania Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73707

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73707

CERTIFICATE OF DEATH.

10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 E. Baltimore ST. No WARD)

2-FULL NAME Gertrude E. Segelken

(a) RESIDENCE NO. 3302 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Child

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry F. Segelken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastport, Md.

12 MAIDEN NAME OF MOTHER Agnes Moreland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Henry F. Segelken

(Address) 3302 E. Baltimore St.

15 Robert P. Harrison, Registrar

MAR 13 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1923

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1923, to March 11, 1923,

that I last saw her alive on March 11, 1923

and that death occurred, on the date stated above, at 7 20 P.m.

The CAUSE OF DEATH* was as follows:

Pharyngeal Paralysis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. B. Neer, M. D.

3/12/1923 (Address) 408 E. East Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	March 14 1923
20 UNDERTAKER	ADDRESS
L. Sander Sons	1710 Eutaw

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Diphtheria

Spec.—8-24-14—M. & T.—2000 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73708 D73708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 529 Preston ST.; 17 WARD) REGISTERED No. C 99-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrrie A Johnson

(Residence in Baltimore: No. 529 Preston St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, femal

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 2 (Month) — 1 (Day), 1922 (Year)

7-AGE, one yrs. one mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Bal

PARENTS.

10-NAME OF FATHER, Scipio Johnson

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER mary thomas

13-BIRTHPLACE OF MOTHER (State or Country), Bal

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..mary Johnson

(Address)..529 W Preston st

15- Robert P. Harrison, 191.....

13 1923 Burial Permit Clerk] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 13 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 8 1923, to March 12 1923, that I saw her alive on March 11 1923, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

1d

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) John E Stewart M. D.

3-12, 1923 (Address) 704 W Lafayette st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cem

DATE OF BURIAL, Mar 14, 1923

20-UNDERTAKER John H Goodwin

ADDRESS 1027 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73709

CERTIFICATE OF DEATH.

175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 N. Central Ave ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard A. Beard.

(a) RESIDENCE NO. 1039 N. Central Ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24th 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Charles Beard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Nellie Kelley.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New Jersey.

14 Informant Nellie Beard
(Address) 1039 N. Central Ave

15 Robert P. Harrison, Registrar

MAR 13 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,

that I last saw h... alive on ..... 19...,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculosis Laryngitis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

..... 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	March 13 1923
20 UNDERTAKER	ADDRESS
Frank A. Fenchel	915 N. Gay St.

DATE SHOULD be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

information should be carefully supplied.

Spec.—1-10-21—M&T—1500 Blks.

D73710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73710

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1909 Christian ST., 20 WARD)

2-FULL NAME Frederick A. Berry

(a) RESIDENCE No. 1909 Christian ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Nicholas Bonnet

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. L. Bonnet
(Address) 1909 Christian St.

15 Robert P. Harrison, Registrar

APR 1 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 12, 1923.

that I last saw her alive on March 12, 1923.

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. D. Kennedy, M. D.

3/13/1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	Mar 14 1923
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	909 Saratoga St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73711 D73711

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1108 E Fort Ave St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alfred H. Clayton

(a) Residence No. 1108 E. Fort Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6-DATE OF BIRTH (month, day and year) Oct 17 1852

7-AGE, 67 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Don't Know

14-(Informant) Julia Dix

(Address) 1108 E Fort Ave

15-MAR 13 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 12 1923

17- I HEREBY CERTIFY, That I attended deceased from Mar 17, 1922 to March 12, 1923

that I last saw h— alive on March 12 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Tim. Seabury, M. D.

3/12, 1923 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cedar Hill — DATE OF BURIAL, March 15, 1923

20-UNDERTAKER Wm Cook — ADDRESS 502 E Fort Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

In plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73712

D73712

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH 1941 Patterson Park ave 8

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Theodore Wells

(a) Residence No. 1941 Patterson Park ave St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 6, 1923

7-AGE. ....yrs. 1 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Leonard Wells

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER, Blanch Gordon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Leonard Wells

(Address) 1941 Patterson Park ave

15- Robert P. Harrison, Registrar.

Filed 13 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-12-23

17- I HEREBY CERTIFY, That I attended deceased from Feb 28 1923 to March 12 1923

that I last saw him alive on March 12 1923

and that death occurred, on the date stated above, at 10 55 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis 3 day

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. T. Reed Jr M. D.

3-12, 1923 (Address) 600 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Fredericksburg Va

DATE OF BURIAL, March 14, 1923

20-UNDERTAKER, Wm Cook - Sons

ADDRESS E Fayette

Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH should be carefully supplied. Note should be made of instructions on back of certificates.

Rev.—12-23-21—E.B.P.S.—400 Blks.

D73713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73713

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Anna Morningstar

(a) Residence No. 429 E. North Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 2 1899

7-AGE, 23 yrs. 5 mos. 11 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, William Morningstar

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Elsie Sleedy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14- (Informant) Wm. Morningstar

(Address) 429 E. North Ave

15- 3/14 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 13 23

17- I HEREBY CERTIFY, That I attended deceased from Feb 21, 1923, to March 13 1923.

that I last saw h.. alive on March 12 1923.

and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Abscess

Uterus Probably

Cancer

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen Peritonitis

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Suppose Uterus + Ovaries

Did an operation precede death? yes Date of 3/9/23.

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) D. J. Sullivan M. D.

, 19 (Address) Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Frederick Md	3/15 1923
20-UNDERTAKER, Wm Cook	ADDRESS 502 E North Ave

AR 1 31923

Filed. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73714

CERTIFICATE OF DEATH.

179 D73714

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1723 N. Port St

CITY OF BALTIMORE: (No. 1723 N. Port St ST., 8 WARD)

2-FULL NAME Sophia Schroder

(a) RESIDENCE NO. 1723 N. Port ST., 8 WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Schroder deceased

6 DATE OF BIRTH (month, day, and year): Nov 17 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: August Buchel (Address): 1723 N. Port St

15 MAR 13 1923 19.. Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Mar 12, 1923, that I last saw her alive on Mar 12, 1923 and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary Test

(Signed) Edward Macfarlane M. D.

Mar 17, 1923 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johns Hopkins Cemetery	Mar 14 1923
20 UNDERTAKER: Robt F Turner Inc	ADDRESS: 17 N. Conway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73715

CERTIFICATE OF DEATH.

129 D73715

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Farrell

(a) RESIDENCE. NO. 2110 Taylor St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 1 mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb. 6, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	—	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: William J. Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rhode Island

12 MAIDEN NAME OF MOTHER: Helen Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md.

14 Informant (Address): William J. Farrell (Father)

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1922 to March 12, 1923.

that I last saw her alive on March 12, 1923.

and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration yrs. mos. ds.)

CONTRIBUTORY (Secondary): Chr. Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. W. Schedrick, M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: March 15 1923

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1421 Light St

MAR 13 1923

mation Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73716 ✓ 74-00 D73716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Dolphin ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Albert Wiggins

(a) RESIDENCE NO. 500 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine Wiggins

6 DATE OF BIRTH (month, day, and year) Feb. 21-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster House

(c) Name of employer Dredge Oyster House

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Albert J. Wiggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Crowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Josephine Wiggins (Address) 500 Dolphin St.

15 Filed Mar 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10- 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 7- , 1923, to Mar. 10- , 1923, that I last saw him alive on Mar. 10- , 1923, and that death occurred, on the date stated above, at 10-10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) - yrs. - mos. 1 ds.

CONTRIBUTORY (Secondary) Cardio Sclerosis & Nephritis

Congestion (duration) - yrs. - mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. L. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Mar. 14 1923

20 UNDERTAKER John M. Johnson — ADDRESS 1254 Ethan St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

D73717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 D73717

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Homewood Hospital ST. 12 WARD)

2-FULL NAME John D. Ayler

(a) RESIDENCE NO. 814 Hellington St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Ayler

6 DATE OF BIRTH (month, day, and year): June 27-1863

7 AGE: Years 59 Months 8 Days 14 IF LESS than 1 day, hrs or..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Welfare Agent.

(b) General nature of industry, business, or establishment in which employed (or employer): Mt. Vern. Woolstory Mills Inc.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Wm. H. Ayler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Jane R. Gladstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant (Address): Mrs. Lila N. Cooper 814 Hellington St.

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8. 1923, to March 13. 1923, that I last saw h (im)alive on March 12. 6 P.M. 1923, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Strangulated Hernia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 814 Hellington St.

Did an operation precede death? Yes Date of March 6, 1923

Was there an autopsy? No

What test confirmed diagnosis? Inspection

(Signed) H. H. Slaughter, M. D.

3/13, 1923 (Address) 7140 Park Ave, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's (Hampden)

UNDERTAKER: Horace H. Burgee

DATE OF BURIAL: March 15 1923

ADDRESS: 363 Falls Rd.

MAR 13 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73718

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. 11th St. Orangeville Ave WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M. Nenwiller

(a) RESIDENCE. No. 916 N. 11th St. Orangeville Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ———

6 DATE OF BIRTH (month, day, and year): Sept. 17-1866

7 AGE — Years: 56 — Months: 5 — Days: 23 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John L. Nenwiller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Emma Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Eva Davis

(Address) 916 N. 11th St. Orangeville

Filed 13 1923

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 12-1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1923, to Mar. 12, 1923, that I last saw h[illegible] alive on March 12, 1923, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Edwin B. Fenby M. D.

3/13/1923 (Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: Mar 14 1923

20 UNDERTAKER: Geo M. Frick & Son

ADDRESS: 911 Mass Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-002

D73719

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME -406-S.-Castle- Anthony Stelnianis

(Residence in Baltimore: No. 406 S. Castle St.; yrs., 14 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write this word.)
male	white	married

6-DATE OF BIRTH. Sept. 20/1877 (Month) (Day) (Year)

7-AGE. 45 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Dry Docks

9-BIRTHPLACE, (State or Country). Lithuania

PARENTS.

10-NAME OF FATHER. Anthony Stelnianis

11-BIRTHPLACE OF FATHER, (State or Country). Lithuania

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). ll

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felicia Stelnianis (wife)

(Address) 406 S.Castle

15- Filed 13 1923 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Basilar Meningitis result of fractured skull- rt. frontal region injury received Mar. 3/23

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Pullen M. D. (Coroner.)

3/13/23 (Address) 508 E.North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary Cem	Mar. 15 1923
20-UNDERTAKER.	ADDRESS
John M. Weber	1803 Bank St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D73720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kweneski.

(a) RESIDENCE NO. 718 S. Ann — ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	61	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed ....., 19 Robert P. Harrison,

Burial Permit Clerk. Registrar

R 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/23

17

I HEREBY CERTIFY, That I attended deceased from 1/22/23, 19..... to 3/12/23 19.....

that I last saw h... alive on 3/12/23, 19.....

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) yrs. 3 mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 7/21/25

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A. Chapman, M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus — DATE OF BURIAL March 16, 19 23

20 UNDERTAKER John N. Weber — ADDRESS 1803 Bank St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D73721

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 N. Payson St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Kate Hahn

(a) Residence No. 13 N. Payson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) March 1856

7-AGE, 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Lawrence Hahn

11-BIRTHPLACE OF FATHER (city or town)
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Schaffer

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Germany

14- (Informant) Geo Hahn

(Address) 13 N. Payson St.

15- Filed MAR 14 1923 ROBERT P. KRAUTER Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 12, 23

17- I HEREBY CERTIFY, That I attended deceased from Mar 5, 1923, to Mar 12, 1923,

that I last saw h alive on Mar 11, 1923,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

3/13 1923 (Address) 1702 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Mch 14, 1923

20-UNDERTAKER. John C. Mish — ADDRESS 1201 W Fayette

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Samuel E. Simpson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73722

CERTIFICATE OF DEATH.

X 100-001

D73722

1-PLACE OF DEATH

CITY OF BALTIMORE: No. University Hospital ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. Simpson

(a) RESIDENCE No. Rogers Ave. ST., Mt Washington WARD England

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Simpson

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer not known

009

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Albert E. Simpson

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Epson

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Hospital Records (Address)

15 MAR 14 1923 ROBERT F. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/8, 1923, to 3/12, 1923, that I last saw h[illegible] alive on 3/12, 1923 and that death occurred, on the date stated above, at 8 am. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation + hypertrophy (duration) [illegible] mos. ds.

18 Where was disease contracted if not at place of death? Mt Washington

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) Wm B Jones, M. D.

3/12, 1923 (Address) Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: Mch 14 1923

20 UNDERTAKER John O. Mitchell ADDRESS 420 N Fayette

CAUSE OF DEATH should be carefully supplied. Any illegible or incomplete statement will delay burial permit. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73723

CERTIFICATE OF DEATH.

3 D73723

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 ST., Municipal tuberculosis Hospital WARD)

2-FULL NAME Grace Holmes

(a) RESIDENCE NO. 232 N. Fremont ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Braxton Holmes

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) New Jersey ?

12 MAIDEN NAME OF MOTHER Catherine Garrett

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) New Jersey ?

14 Informant Hospital Records
(Address) M.T.H.

15 Filed MAR 14 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1923

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1923, to March 10, 1923, that I last saw her alive on March 10, 1923, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? B.B. in sputum. X-ray

(Signed) Frances L. Sedgwick M. D.

3-10-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 3-14 1923

20 UNDERTAKER Arnd Eastwood — ADDRESS 916 Park ave

IMPORTANT: Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 ✓

D73724

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2571 Edmondson Ave ST., 20 WARD)

2-FULL NAME Martha A. Austin

(a) RESIDENCE NO. 2571 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) J. L. Austin

15 MAR 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11" 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to March 11, 1923, that I last saw h alive on March 11, 1923, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

8 (duration) — yrs. — mos 25 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. N. Duvall, M. D.

3/12, 1923 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 3-14 1923

20 UNDERTAKER David Easton

ADDRESS 916 Park Ave

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73725 HEALTH DEPARTMENT—CITY OF BALTIMORE D73725

66

CERTIFICATE OF DEATH.

REGISTERED No. C..

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James R. Smedley

(Residence in Baltimore: No. 1103 W. Appleton St. St. 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., (Month) (Day) 1878 (Year)

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Barber
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER James Smedley

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary Triggins

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Kattie Shank

(Address) 1912 Harlem ave

15- MAR 14 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11th, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

3cd Hem, Cause of death at Put time Mercy Hosp held Cata Mrs & was sign Put until Acute Alcoholism

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D. (Coroner)

March 13, 1923 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cem

DATE OF BURIAL, 3-14, 1923

20-UNDERTAKER David Easton

ADDRESS 716 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 lbs.

D73726

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D73726

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1346 GLYNDON AVE ST., 21 WARD)

2-FULL NAME LEVENARDAS PECULIS

(a) RESIDENCE NO. 1346 GLYNDON AVE ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3th 1922

7 AGE 1 Years -- Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daminik Peculis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Elen Levonas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Daminik Peculis
(Address) 1346 Glyndon Ave

15 Filed MAR 14 1923. 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13. 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 9, 1923, to Mar. 13 1923, that I last saw him alive on Mar. 12, 1923, and that death occurred, on the date stated above, at 1th P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Mar. 13 1923 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer [illegible]	Mar 16 19 23
20 UNDERTAKER	ADDRESS
John L. Rebbeck [illegible]	425 S. Lan[illegible] St

IMPORTANT. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-D73727 — 44 D73727

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST.: 24a WARD)

2-FULL NAME Anthony Matthews

(a) RESIDENCE NO. 1824 Orchard Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 19 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov. 30-1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 880

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Eva

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed MAR 14 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 17th, 1923 to March 13, 1923, that I last saw h[illegible] alive on March 13, 1923 and that death occurred, on the date stated above, at 1:22 a.m.

The CAUSE OF DEATH* was as follows: Perforated Ulcer of Stomach for Carcinoma

Carcinoma, Stomach

(duration) ..... yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Enlarged Pancreas (duration) ..... yrs. ..... mos. 22 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 16/23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Geo. W. Holman, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney Cem.

DATE OF BURIAL: Mar 15 1923

20 UNDERTAKER: John Stallinecker

ADDRESS: 405 S. [illegible]

Should be filled out correctly. Supplies. ASK. Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73728

CERTIFICATE OF DEATH.

178 D73728

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Leadenhall ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Fitchett

(a) RESIDENCE. No. 819 Leadenhall ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Fitchett

6 DATE OF BIRTH (month, day, and year) July 30, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48 yrs.		7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer): 69

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Hampton Co. Virginia

PARENTS

10 NAME OF FATHER: Bonnell Widgeon

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Hampton Co Virginia

12 MAIDEN NAME OF MOTHER: Hann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

11 Informant: Mildred Fitchett (Niece)
(Address) 819 Leadenhall St

13 Filed MAR 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11" 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28" 1923, to Mar. 11" 1923, that I last saw h[illegible] alive on Mar. 11" 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
Exposure

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of?

Was there an autopsy? no

What test confirmed diagnosis? Urinary Exam.

(Signed) J. T. Shellode, M. D.

3/13, 1923 (Address) 203 N. Hanby St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
East Ville sta, North Hampton Co Va	Mch 14 1923
20 UNDERTAKER	ADDRESS
N. H. Brown and Son	1611 N. Monty

Route Chesapeake Line to old Point RR to East Ville Va

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Sharp ST., 27 WARD)

REGISTERED NO. 161-801 D73729

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gray

(a) RESIDENCE No. 820 Sharp ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Singer

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 12, 23

7 AGE	Years	Months	Days	If LESS than 1 day 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Howard Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Mondell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Howard Gray
(Address) 820 Sharp St

15 FILED MAR 14 1923 ROBERT F. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 12, 1923, to Mar 12, 1923, that I last saw her alive on Mar 12, 1923, and that death occurred, on the date stated above, at 8,30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth (7 mo)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? —

(Signed) D. H. Laurel, M. D.

3/13 1923 (Address) 140 W. Lieb St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	March 14 23
20 UNDERTAKER	ADDRESS
S. H. Brown & Son	1081 W. Mont'y

BEFORE SIGNING BE CERTAIN ALL ITEMS are correctly and completely answered. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73730 HEALTH DEPARTMENT—CITY OF BALTIMORE D73730

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Frank Markos

(a) Residence No. 24 E. Madison St, St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) Nov. 24 1871

7-AGE. 51 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Frank Markos

11-BIRTHPLACE OF FATHER (city or town) Wash. (State or Country), D.C.

12-MAIDEN NAME OF MOTHER, Mariah Thomas

13-BIRTHPLACE OF MOTHER (city or town) Mary Land (State or Country),

14 (Informant) John Markos

(Address) 907 St Paul St.

15- MAR 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 13 23

17- I HEREBY CERTIFY, That I attended deceased from Mar. 2 19 23 to Mar 13 19 23

that I last saw h. living alive on Mar 13 19 23

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam & Clinical Symptoms

(Signed) [illegible] M.D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Corans — DATE OF BURIAL. 3-15 1923

20-UNDERTAKER Laurence Fenstermacher Co — ADDRESS McCulloh Orchard St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001
D73731

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 W. Pratt St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Marion Arnold

(a) RESIDENCE NO. 1607 W. Pratt St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14" 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Marion Arnold

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie Karbowsky

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Marion Arnold
(Address) 1607 W. Pratt St.

15 Filed MAR 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 13" 19 23

17 I HEREBY CERTIFY, That I attended deceased from 3/10/23, 19, to 3/13/23, 19, that I last saw him alive on 3/12/23, 19, and that death occurred, on the date stated above, at 12.05 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. Winsor, M. D.

(Address) 1302 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk. Cemetery

DATE OF BURIAL Mch 15 1923

20 UNDERTAKER A. B. Cook

ADDRESS 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73732

CERTIFICATE OF DEATH.

90 D73732

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1729 Wilkens Ave ST.: 19 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J. Harris

(a) RESIDENCE. No. 1729 Wilkens Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of ~~WIFE~~ of Mary E. Harris

6 DATE OF BIRTH (month, day, and year) June 6th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R. R.

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): Halifax Co. Va.

PARENTS

10 NAME OF FATHER: Dr M. A. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary E.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs Mary E. Harris

(Address) 1729 Wilkens Ave

15 FILED MAR 14 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1922, to March 12, 1923.

that I last saw him alive on March 12, 1923.

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation,

(duration) ✓ yrs. ✓ mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Arterio sclerosis Myocarditis Cystitis & Prostatitis

(duration) Chronic 3 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? Yes Physical Examination

What test confirmed diagnosis?

(Signed) Henry C. Harris M. D.

Mch 14 1923 (Address) 1283 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mch 15 1923
20 UNDERTAKER: Jos B Cook	ADDRESS: 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D73733

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Arlington Ave ST., 16 WARD)

2-FULL NAME John Gaw

(a) RESIDENCE NO. 716 N. Arlington Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12" 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Gaw

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Henrietta Ray

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant Miss Henrietta Gaw
(Address) 716 N. Arlington Ave.

15 Filed MAR 14 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 13" 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Mar 13, 1923, that I last saw h[illegible] alive on Mar. 11, 1923, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) John S Richards, M. D.

3/13 1923 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk. Cemetery	Mch. 15 1923
20 UNDERTAKER	ADDRESS
J. R. Cook	1023 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16 D73734 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D73734

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 20 WARD)

2-FULL NAME Robert B Winters

(a) RESIDENCE NO. 1914 (1433) W Franklin St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Mar 1-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 29

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Abraham Winters

11 BIRTHPLACE OF FATHER (city or town) Catonsville
(State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Amanda Evans

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant (Address) Johns Hopkins Hospital JOHNS HOPKINS HOSPITAL

15 Filed MAR 14 1923 ROBERT F. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 8 - 1923, to Mar 12, 1923;

that I last saw him alive on Mar 12 - 1923;

and that death occurred, on the date stated above, at 3.20 P m.

THE CAUSE OF DEATH* was as follows:

Carcinomatosis
Peritonitis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Bugg M.D.

3/13 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Mch 14 1923
20 UNDERTAKER Jos B Cook	ADDRESS 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73735

HEALTH DEPARTMENT—CITY OF BALTIMORE

D7373[illegible]

CERTIFICATE OF DEATH.

148

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1330 Sargeant St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida May Morhiser

(Residence in Baltimore: No. 1330 Sargeant St. St.; yrs., 5 mos., 10 ds.)

40

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. October (Month) 3rd (Day) 1882 (Year)

7-AGE. 40 yrs. 5 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John W. Shipley

11-BIRTHPLACE OF FATHER, (State or Country). Elkridge, Md.

12-MAIDEN NAME OF MOTHER. Ida May Chaney

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles F. Morhiser

(Address) 1330 Sargeant St.

15- FILED MAR 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 13th (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said decreased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lacerated Perineum
(Puerperal)

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Acute dilatation, heart
which is also (Duration) 2 yrs. mos. ds.

(Signed) James H. Benton M. D.
(Coroner.)

Mch. 13 1923 (Address) 700 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Pk Cemetery DATE OF BURIAL. Mch. 16 1923

20-UNDERTAKER. Jos B Cook ADDRESS 1003 W. Balto.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D73736

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE (No. 4 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bodley

(a) RESIDENCE NO. 310 N. Pine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~: Florence Bodley

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 51. Months Days

If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country): Maryland. (Baltimore)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bayview Hospital Balto, Md.

MAR 14 1923 ROBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1922, to March 11, 1923

that I last saw him alive on March 10, 1923

and that death occurred, on the date stated above, at 12:59 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmhoge

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptomatic

(Signed) H. W. Edwards M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: 3/14 1923

20 UNDERTAKER: Samuel Hemsley ADDRESS: Mt. Auburn

mation should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73737

CERTIFICATE OF DEATH.

124 D73737

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 16 WARD)

2-FULL NAME Lucy A. Minor

(a) RESIDENCE NO. 1322 Longwood ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry C. Minor

6 DATE OF BIRTH (month, day, and year) Sept 16 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Madison Minor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa Jeffries

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant W. J. Dew Robinson
(Address) 1302 Longwood St

15 MAR 14 1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3 1923, to March 12 1923.
that I last saw her alive on March 12 1923,
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes No Date of March 7-1923 Cholecystotomy

Was there an autopsy?

What test confirmed diagnosis? Operation & Clinical

(Signed) James Hurst Wilkinson, M. D.

19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mch 1923

21 UNDERTAKER W. P. Cushwa & Sons — ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73738

CERTIFICATE OF DEATH.

90 D73738

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1681 W North Ave ST. 15 WARD)

2-FULL NAME Sarah M. McKee

(a) RESIDENCE NO. 1681 W. North Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James McKee

6 DATE OF BIRTH (month, day, and year) Sept 11. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... mlo.
	77	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, professioo or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Brosius

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) James F. McKee 1681 W. North Ave

15 MAR 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 8, 1923, to Mar 11, 1923, that I last saw h alive oo Mar 11, 1923, and that death occurred, oo the date stated above, at 10-30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if oot at place of death?

Did an operatioo precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emlen Wheeler, M. D.

3/11, 1923 (Address) 2129 Wyoming Ave

*State the Disease Causing Death, or in deaths from Violeot Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Mar 14, 1923
20 UNDERTAKER	ADDRESS
Wm J Ricketts Sons	North Ave

mation should be entirely supplied. Age should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D7373 CERTIFICATE OF DEATH. D7373

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Belvedere Ave. St., 27 WARD) Near Pimlico Road

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. M.

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Unknown

6 DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)

7 AGE 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE, (State or Country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (State or Country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (State or Country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed MAR 14 1923 19[illegible] ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH Feb 27, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gen. Chronic Nephritis
Heart Disease
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Duff Hollins M. D.
(Corner) 1923 (Address) 3632 Roland

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL, 19[illegible]

20 UNDERTAKER Commissioner Health, ADDRESS WOODALL. MAR 13 1923

THE MORGUE.

0208

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73740

CERTIFICATE OF DEATH.

129

REGISTERED No. D73740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Wagon Alley ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Snowdon

(a) RESIDENCE NO. 1025 Wagon Alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Octavia Snowdon

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	39	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Building 140

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Walter Queen

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Frances Snowden

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Octavia Snowden
(Address) 1025 Wagon Alley

15 MAR 14 1923 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/1923

17 I HEREBY CERTIFY, That I attended deceased from 3/3/1923, to 3/12/1923, that I last saw h[illegible]ive on 3/12/1923, and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Immediate ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. H. Revell M. D.

3/14, 1923 (Address) 409 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 15 1923
20 UNDERTAKER Brown & Freeland & Schroder	ADDRESS 114 W. [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Infant · Coyne ·

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73741

CERTIFICATE OF DEATH.

162 D73741

1-PLACE OF DEATH Stemmers Run

CITY OF BALTIMORE: (No. 2724 N Charles ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME unnamed

(a) RESIDENCE NO. 5156 Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, —hrs. or 1 min.
1 Minute	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unnamed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Coyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward Coyne
(Address) 516 E Chase St

15 Filed MAR 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1923, to March 13, 1923.

that I last saw h alive on March 13, 1923

and that death occurred, on the date stated above, at 5.01 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos 2 hrs. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L Grant M. D.

3/14 1923 (Address) 1717 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	3/14/23
20 UNDERTAKER	ADDRESS
H C Wedefeld	914 Fremont Ave

D73742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D73742

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1602 McElderry St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Courtney

(Residence in Baltimore: No. 1602 McElderry St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. Feb. 19, 1851 (Month) (Day) (Year)

7-AGE. 72 yrs. mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Former Gardner
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. MD.

PARENTS:

10-NAME OF FATHER. John Courtney

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. Rachel Herring

13-BIRTHPLACE OF MOTHER. (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nancy Seed.

(Address) 1602 McElderry St.

15-MAR 14 1923 Filed 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-Fractured skull, left parietal region. Elevator accident at Hopkins' Hosp. 10 yrs ago. HH

Duration..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(Duration)..... yrs..... mos..... ds.

(Signed) G. E. H. Cotton M. D. (Coroner.)

3/13/23 192... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemeteries	3/14 19 23

20-UNDERTAKER.	ADDRESS
Wm. H. Forst	444 N. Broadway.

THE CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Wm D Zimmer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73743

CERTIFICATE OF DEATH.

90 D73743

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 St Peters st St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm D Zimmers

(Residence in Baltimore: No. 711 St Peter st St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: (Month) Dont Know (Day) (Year) 1848

7-AGE: 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nom
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: John F Zimmers

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Eliz Buckess

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mora E. Easton

(Address) Locust & Oak Av Overlea

15- Filed MAR 14 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: March (Month) 13 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or Inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or Inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(Duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D. (Coroner.)

3-13 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: 3-16th 1923

20-UNDERTAKER: Wm Cook

ADDRESS: 502 E. North Ave

CAUSE OF DEATH in plain terms. ... that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D73744

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D73744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1336 Hollins St St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Albert C. Getz

(a) Residence No. 1336 Hollins St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Leonora Getz

6-DATE OF BIRTH (month, day and year) Oct 17 1881

7-AGE. 41 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Fred Getz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Leonora Getz

(Address) 1336 Hollins St

15-FILED MAR 14 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 13, 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1923 to March 12, 1923

that I last saw h[illegible] alive on " " 1923

and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Ac Dilitation of Heart

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of

Was there an autopsy? "

What lest confirmed diagnosis? Clinical

(Signed) Edw. L. Coolahan, M. D.

3/13, 1923 (Address) 21 X Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL, Mar 16, 1923

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North

Exact statement of OCCUPATION is very important. See that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73745

CERTIFICATE OF DEATH.

D73745

REGISTERED NO.....

1-PLACE OF DEATH 2629 Bernard St (12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.....

2-FULL NAME John T. Boyer

(a) RESIDENCE. NO. 2629 Bernard St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~
male	White	married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Carrie Boyer

6 DATE OF BIRTH (month, day, and year) Mar. 18, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hope Town. Co

9 BIRTHPLACE (city or town) (State or country) a. a. Co, Md

PARENTS

10 NAME OF FATHER Chas Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) a. a. Co, Md

12 MAIDEN NAME OF MOTHER Mary Disney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) a a Co, Md

14 Informant Carrie Boyer (Address) 2629 Bernard St

15 [illegible] MAR 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923, to March 12, 1923, that I last saw h[illegible] alive on March 12, 1923, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Cardeac Failure
Pneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver (duration) yrs. mos. ds.

18 Where was disease contracted if not ut place of death? —

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C A Richardson, M. D.

March 14 1923 (Address) 1124 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, [illegible] St Mary Cemetery — DATE OF BURIAL Mar 15 1923

20 UNDERTAKER Wm Leork - 502 E North Ave — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73746

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D73746

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Pine Crest Sanatorium Dolwood Ave 16 ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louise Compton

(Residence in Baltimore: No. 2920 W North Ave St.; Age yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH April 6, 1833 (Month) (Day) (Year)

7 AGE 89 yrs. 11 mos. 4 ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (State or country) Unk

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (State or country) Unk

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wall

(Address) 2920 W North Ave

15 Filed MAR 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 12, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1922, to March 12 1923 that I saw h[illegible] alive on March 12, 1923 and that death occurred, on the date stated above, at 11 30 p m
The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Marshall B Krat M. D.

March 13, 1923 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)
At place of death 2 yrs. mos. ds. In the State 89 yrs. mos. ds.
Where was disease contracted, if not at place of death? Balto Md
Former or usual residence 2920 W North Ave

19 PLACE OF BURIAL OR REMOVAL Western Cemetery | DATE OF BURIAL 3/15, 1923

20 UNDERTAKER W M Cook | ADDRESS 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D73747

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 S Madeira ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michaeline Lorek –

(a) RESIDENCE No. 501 S. Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow.

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Thomas Lorek –

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE: Years 83; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mrs. Rose Heaphy. 501 S. Madeira St

15 FILED MAR 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/23 - 19

17 I HEREBY CERTIFY, That I attended deceased from 2/25, 19 23, to 3/12, 19 23, that I last saw her alive on 3/11, 19 23, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial nephritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Rupkus, M. D.

3/12, 19 23 (Address) 2939 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem., DATE OF BURIAL: Mar. 15. 1923.

20 UNDERTAKER: W. F. Sadowski, ADDRESS: 705 S. Ann St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73748

CERTIFICATE OF DEATH.

90 D73748

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 S. Ann ST.; 2 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Caroline Hellas

(Residence in Baltimore: No. 531 S. Ann St. St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W.

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (*Write* the word.) Widow

6-DATE OF BIRTH, 4/2/1842, 1 (Month) (Day) (Year)

7-AGE. 80 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. HH
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER, Ludwik Kozakiewicz

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Machulay Daughter

(Address) 626 S. Bond St.

15-MAR 14 1923 Filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3/13/23, 191... (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from 3/11/23 191..., to 3/13/23 191..., that I saw h[illegible] alive on 3/13/23 191..., and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

..... (Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Hermann M. D.

3/14/23 191... (Address) 719 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Cross Nat. Cem. DATE OF BURIAL. March 16, 1923

20-UNDERTAKER W. F. Sadowski ADDRESS 705 S. Ann St

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D73749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73749

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat St. 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Kerr

(a) RESIDENCE. No. Mt Hope Retreat St. 28 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 22 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress -

(b) General nature of industry, business, or establishment in which employed (or employer) Sewing - 069

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jonas Kerr

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary (?)

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md.

15 MAR 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 12th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 9th, 1917, to Mch 12th, 1923, that I last saw h. alive on Mch 12, 1923, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows: —

Angina Pectoris -

Cab

(duration) 0 yrs. 0 mos. 1/2 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -

Cab (duration) 7 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Mch 13, 1923 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Mch 15 23

20 UNDERTAKER Geo R Talley Sutton & Fayette ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73750

CERTIFICATE OF DEATH.

23 D73750

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 E. Preston ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Bandel

(a) RESIDENCE NO. 1006 E. Preston ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug - 47

7 AGE — Years: 75 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Philip Bandel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Aramida —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Eda Hall
(Address): 1006 E. Preston

15 Filed MAR 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/12 1923

17 I HEREBY CERTIFY, That I attended deceased from October, 1920, to March 12, 1923, that I last saw her alive on March 11, 1923, and that death occurred, on the date stated above, at 7-15 A m.

The CAUSE OF DEATH* was as follows:

Progressive Bulbar Paralysis

Cause

(duration) 10 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert Eskridge, M. D.

March 13, 1923, 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bals Cem — DATE OF BURIAL: 3/14 1923

20 UNDERTAKER: Philip Henry — ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73751

CERTIFICATE OF DEATH.

159-002

D73751

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 127 N. Luzerne ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Martha Ehrman

(a) RESIDENCE. No. #127 N. Luzerne ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 12/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Barry G. Ehrman

11 BIRTHPLACE OF FATHER (city or town) Ind.
(State or country)

12 MAIDEN NAME OF MOTHER Martha B. Oetzer

13 BIRTHPLACE OF MOTHER (city or town) Ind.
(State or country)

14 Informant Barry G. Ehrman
(Address) 127 N. Luzerne Ave.

15 MAR 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1923 to March 13, 1923.
that I last saw her alive on March 13, 1923
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Partial Asphyxiation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. Edema Lungs mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Lee M. D.

19 (Address) #541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	3/14 1923
20 UNDERTAKER Philip Derring	ADDRESS 2016 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73752

CERTIFICATE OF DEATH.

90 D73752

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 Belair Ave ST. 8 WARD)

2-FULL NAME Eliza A. Smith

(a) RESIDENCE NO. 2304 Belair Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ the late Samuel F. Smith

6 DATE OF BIRTH (month, day, and year) Nov 19 - 53

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Geo. Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Marsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Rutter

(Address) 4339 Harford Av

15 Filed MAR 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10 1923, to March 12 1923, that I last saw h[illegible] alive on March 12 1923, and that death occurred, on the date stated above, at 1:30 P, m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John G. Wade M. D.

(Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL 3/15 1923

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73753

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3512 Clifton Ave (St.) 15 (Ward)

2-FULL NAME Elizabeth R. Lyon

(a) RESIDENCE. No. 3512 Clifton Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 10, 1840

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
82	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York State

PARENTS

10 NAME OF FATHER: Thos. Nevers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eng.

12 MAIDEN NAME OF MOTHER: Decima Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eng.

14 Informant: Mrs. Helen L. Ransom
(Address): Atkinson Md

15 Filed MAR. 14 1923

16 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar-14 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar-10- 1923. to Mar 14 1923.

that I last saw her alive on Mar.-10 1923.

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
coming hemiplegia
left side (Apoplexy)
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis
Senile (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Nox Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H Wesley Cale, M. D.

3/14 1923 (Address) 2202 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Atkinson Md.	March 16 1923
20 UNDERTAKER: George D. Smith	ADDRESS: 1552 Hoe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21 M&T 1500 Blks.

D73754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73754

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hynson

(a) RESIDENCE NO. 1927 Brunt st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1895 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Morgan Hynson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M. C. H.

15 MAR 14 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to March 13, 1923, that I last saw him alive on March 13, 1923, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 ? mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances L. Dadaplucci, M. D.

3-13-23 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	March 15 1923
20 UNDERTAKER James A. Dunn	ADDRESS 1203 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73755

CERTIFICATE OF DEATH.

101-001 D73755

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 Parrish St., 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Smallwood

(a) RESIDENCE NO. 1135 Parrish St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Smallwood

6 DATE OF BIRTH (month, day, and year): Sept 1st 1882

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
40		6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bartender

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: not known 044

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Nicholas Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza E. Rambell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Eliza E. Smallwood

(Address) 1135 Parrish St.

15 MAR 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 9th, 1923, to Mar 10th 1923.

that I last saw h[illegible] alive on Mar 10th, 1923,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical -

(Signed) Harry F. Brown, M. D.

3/12 1923 (Address) 1501 Freedman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Mar. 14 1923

20 UNDERTAKER: James H. Dennis — ADDRESS, 307 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Selle. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73756

CERTIFICATE OF DEATH.

44 D73756

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Mulberry East ST., 20 WARD)

2-FULL NAME Mary Eva Selle

(a) RESIDENCE NO. 421 Mulberry East ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Fred'k C. Selle

6 DATE OF BIRTH (month, day, and year): Sept 9-1842

7 AGE — Years: 80 — Months: 6 — Days: 3 — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (City or town) (State or country): Washington D. C.

PARENTS

10 NAME OF FATHER: Henry Linsau

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Reichard

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant (Address): Ida Frehnger 421 Mulberry East

15 MAR 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to March 12, 1923, that I last saw her alive on March 12, 1923 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) ... yrs. ... mos ... ds. intense

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A Cot, M. D.

(Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: March 14 1923

20 UNDERTAKER: F B Weisheit — ADDRESS: 2336 Fred'k Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73757 HEALTH DEPARTMENT—CITY OF BALTIMORE D73757

CERTIFICATE OF DEATH. 65-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 N. Bond St ST., 6 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mendel Greenberg

(a) RESIDENCE NO. 19 N. Bond St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fanny

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing
(b) General nature of industry, business, or establishment in which employed (or employer) Mfg
(c) Name of employer 045

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Hyman Greenberg

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Serwi Mendelowitz

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Jack Lewis
(Address) 1439 E. Balto St

15 Filed MAY 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/12, 1923, to 3/13, 1923, that I last saw h/e alive on 3/13, 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Acute lymphatic leukemia

(duration) yrs. 6 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Zinberg M. D.
3/14, 1923 (Address) 1826 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kehreh Israel DATE OF BURIAL 3/15 1923

20 UNDERTAKER Jack Lewis 1439 E. Balto St ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73758

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 W Shorthare ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Amernick

(a) RESIDENCE NO. 2319 W. Shorthare ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 22 mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl Amernick

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) cigars Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Amernick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha Perilas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1434 S Balto St

15 Filed MAR 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1923, to March 13, 1923, that I last saw him alive on March 13, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jacob Cohen, M. D.

3-14-1923 (Address) 2235 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rest Carmel	3/14 1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1434 S Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73759

CERTIFICATE OF DEATH.

6 90

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1828 E. Fayette St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Hyman Katz .....

(Residence in Baltimore: No. 1828 E. Fayette St(yrs., 20)mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
male	white	married

6-DATE OF BIRTH, ... unknown ..... 1.....
(Month) (Day) (Year)

7-AGE. 55 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Moretz Katz ~~unknown~~

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Rosa unknown ~~unknown~~

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Jack Lewis

(Address) 1439 E. Balto. Md.

15- Filed MAR 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronic Failure
(Probably Valvular Insufficiency from history)
(Duration) 6? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

3/14/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence. .....

19-PLACE OF BURIAL OR REMOVAL, Fairview, Towson, Md. DATE OF BURIAL, March 16-23

20-UNDERTAKER, Jack Lewis ADDRESS 1439 E. Balto

THIS CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73760 ✓ D73760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH 204 W. 2nd St 12 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Mundt

(a) Residence No. 204 W. 2nd St St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (~~Write the word~~) Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ Carrie Mundt

6-DATE OF BIRTH (month, day and year) June 30, 1872

7-AGE, 50 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Chef
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]
(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Germany

PARENTS.

10-NAME OF FATHER, Louis Krum

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise Krum

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Germany

14- (Informant) Carrie Mundt

(Address) 204 W. 2nd St

MAR. 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 13 23

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1923 to March 13, 1923

that I last saw h~~e~~ alive on March 13, 1923,

and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute nephritis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) I Frederick Lutz, M. D.

3-14, 1923 (Address) 2040 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Boundbrook NJ DATE OF BURIAL, Mar. 16, 1923

20-UNDERTAKER, Wm. Cook ADDRESS 502 Gilmor Av.

Instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73761

CERTIFICATE OF DEATH.

91-002 D73761

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Oldelbuttle

(a) RESIDENCE NO. 718 N. Charles St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 MAR 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1917, to March 13, 1923, that I last saw him alive on March 13, 1923, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Reports

What test confirmed diagnosis?

(Signed) Clyde Kneil, M. D.

3-14-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/14 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

Durfey.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73762

CERTIFICATE OF DEATH.

90 D73762

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Gorsuch Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte D. Durfey

(a) RESIDENCE NO. 515 Gorsuch ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Durfey

6 DATE OF BIRTH (month, day, and year) Aug. 10th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	78	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)

PARENTS

10 NAME OF FATHER Fred Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant D C Kramer (Address) 515 Gorsuch Ave.

15 MAR 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug, 1920, to Mch 13, 1923, that I last saw h[illegible] alive on Mch 12, 1923, and that death occurred, on the date stated above, at 2 PM m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Kinzer M. D.

3/13, 1923 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick, Md.	3/14/1923
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son-19386	Lafayette Ave.

Spec.—1-10-21—M&T—1500 Blks.

Sulev ✓

D73763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D73763

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 14 WARD)

2-FULL NAME Fillian Sutter

(a) RESIDENCE No. 1617 Fillmore ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Entire mos. Life
(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo Sutter

6 DATE OF BIRTH (month, day, and year) Jan 20, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) Boston Mass.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Erickson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sweden

12 MAIDEN NAME OF MOTHER Lillian Carlson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mass.

14 Informant Geo Sutter
(Address) 1617 Fillmore St.

15 Filed MAR 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12- 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-10- , 1923, to 3-12- , 1923, that I last saw her alive on 3-12 , 1923, and that death occurred, on the date stated above, at 4 0m p.m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home upon normal labor

Did an operation precede death? No Date of 2.19.23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Newton J. Carr, M. D.

(Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Mar 15 1923

20 UNDERTAKER Josiah Taylor ADDRESS 1600 Ar North

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-01 D73764

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lafferty

(a) RESIDENCE. No. 1632 N. Smallwood ST.; WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Lafferty

6 DATE OF BIRTH (month, day, and year): May 14 1846

7 AGE: Years 76; Months 9; Days 16; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Chas Heigerhimer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Sarah Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs J. Young

(Address): 1720 Eastern Ave

15 FILED MAR 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1923, to March 12, 1923, that I last saw h[illegible] alive on March 12, 1923, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary): Heart Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1632 N Smallwood.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope

(Signed) Albert J Conrey, M. D.

, 19 (Address) Vol of Am. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 15th 1923
20 UNDERTAKER	ADDRESS
Josiah Lyer	1611 N North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73765

CERTIFICATE OF DEATH.

74-001

D73765

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 W. Lanvale ST. 16 WARD)

2-FULL NAME Augustus S. Wilson

(a) RESIDENCE NO. 1309 W. Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula R. Wilson

6 DATE OF BIRTH (month, day, and year) Jan 31st, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ass't Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) Superior Court

(c) Name of employer Balto. City.

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph A. Wilson

11 BIRTHPLACE OF FATHER (city or town) Prince Frederick (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah E. Sollers

13 BIRTHPLACE OF MOTHER (city or town) Prince Frederick (State or country) Md.

14 Informant Mrs Lula R. Wilson

(Address) 1309 W. Lanvale St

15 MAR 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th, 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 15 , 1923 , to Mar 13 , 1923 , that I last saw him alive on March 12 , 1923 , and that death occurred, on the date stated above, at 1.15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterial sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood pressure

(Signed) O. P. Hourse M. D.

3/14 1923 (Address) 103 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar 15th 1923

20 UNDERTAKER Peterman & Fose ADDRESS 1723 W. Lafayette Ave

Spec.—1-10-21—M&T—1500 Blks.

D73766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D73766

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3348 Cedar Ave. 13 WARD)

2-FULL NAME Rachel F. Smith

(a) RESIDENCE No. 3348 Cedar Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Smith

6 DATE OF BIRTH (month, day, and year): Nov 8 1870

7 AGE: Years 52 Months 4 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): J. M. Schweikart 1500 Edgecroft

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to March 11, 1923, that I last saw h[illegible] alive on March 11, 1923, and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Rheumatic Fever

(duration) yrs. mos. 29 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Signs

(Signed) A. J. Davies, M. D.

3-12-1923 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hereford Highland Co Md DATE OF BURIAL: March 15 1923

20 UNDERTAKER: Chenoweth Son ADDRESS: Chestnut [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73767

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73767

CERTIFICATE OF ~~DEATH~~.

90

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bayly

(a) RESIDENCE No. 1227 Druid Hill Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Coachman 23

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia Culpeper

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital

~~Robert E. Garrison, Md.~~

15 Jan 3 1923

17 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1923. to March 12, 1923.

that I last saw him alive on March 12, 1923

and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia Edema

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) A. Edsmith, M. D.

. 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	March 6 1923
20 UNDERTAKER	ADDRESS
Wm Robert & Edsall	Oakland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

D73768

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73768

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 115 N. High St. 5 Ward)

Registered No. C. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Hall

(Residence in Baltimore: No. 115 N. High St. 5 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Wid

6-DATE OF BIRTH: Sept. (Month) 6 (Day) 1849 (Year)

7-AGE: 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shirt maker
(b) General nature of industry, business, or establishment in which employed (or employer): Sh

9-BIRTHPLACE, (State or Country): N. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie Woodman

(Address) 115 N. High St

15. Filed 4 1923 Robert F. Harrison, 192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 9 (Day) 23 (Year) 192

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

multiple tuberculosis

4 days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

March 13 192 (Address) 16 E. 29 St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery DATE OF BURIAL, March 14 1923

20-UNDERTAKER, Mrs Robert H. Allen ADDRESS 1725 Calhoun

R

IMPORTANT—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73769

D73769

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto - Eye & Ear Hosp. REGISTERED NO. 1003

CITY OF BALTIMORE: (NO. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd Branch

(a) RESIDENCE. NO. 2327 Druid Hill Ave. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Brother

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Va.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Richard Branch

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Annie Miller

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Hospital Records (Address)

15 Filed 1 1 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-3, 1923, to 3-12, 1923 that I last saw h. alive on 3-12, 1923 and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 5 hrs.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of 3-3-23

Was there an autopsy? yes glaucoma

What test confirmed diagnosis? Exam.

(Signed) F. G. Holden, M. D.

. 19 (Address) 625 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	March 15 1923
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Oakland Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73770

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ag. Ruth Sloman

(a) Residence No. Schroeder + Franklin Sts St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 25, 1922

7-AGE.	If LESS than 1 day,
....yrs. 9 ....mos. ....ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME OF FATHER, Alfred Sloman

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Mildred Blythe

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

11- (Informant) Mildred Sloman

(Address) Schroeder & Franklin Sts

15- Mar 14 1923 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 17 1923

17- I HEREBY CERTIFY, That I attended deceased from Mar 8, 1923, to Mar 17, 1923, that I last saw h.. alive on Mar 17, 1923, and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardio Respiratory Failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Schroeder + Franklin

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Findings

(Signed) Daniel J. Finnegan, M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Schwarzbe	Mar 21, 1923
20-UNDERTAKER, Burkert Gibbons	ADDRESS 1739 Eager

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73771

D73771

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Homewood Ave ST., 90 WARD)

2-FULL NAME Rosina L Strohmeyer

(a) RESIDENCE NO. 1216 Homewood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene

6 DATE OF BIRTH (month, day, and year) Feb 22 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	74		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City (State or country)

PARENTS

10 NAME OF FATHER Geo. Merritt

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Eugene Strohmeyer (Address) 1216 Homewood Ave.

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 5/23 19 .., to March 13, 1923.

that I last saw her alive on March 13, 1923.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Vavulen Heart Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W H Gage, M. D.

, 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	March 16 1923
20 UNDERTAKER Fiekler & Fiekler	ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

14 1923

Spec.—1-10-21—M&T—1500 Bks.

D73772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73772

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 S 15th ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Arthur

(a) RESIDENCE NO. 522 S. 15th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Arthur

6 DATE OF BIRTH (month, day, and year) Dec. 26-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	65	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Anywhere

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Patrick Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Dowd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Thos J Arthur

(Address) 522 S 15th St

15 Robert F. Harrison, . 19

Burial Permit Clerk Registrar

14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to March 12, 1923, that I last saw him alive on March 11, 1923, and that death occurred, on the date stated above, at 6-30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Jod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bur Cathedral Cem.

DATE OF BURIAL 3/15/1923

20 UNDERTAKER J. A. Moran

ADDRESS 3000 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73773

CERTIFICATE OF DEATH.

41

D73773

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Fallo Gen Hosp ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Brucka:

(a) RESIDENCE NO. 847 Collington Ave: ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov 23 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoress 880

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER: Vaclav Brucka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Mary Kvlelo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Vaclav Brucka

(Address): 847 Collington Ave

15 4 1923 Robert P. Garrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12 1923

17

I HEREBY CERTIFY, That I attended deceased from March 10 1923 to March 13 1923

that I last saw her alive on March 3 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Septicemia (Coccus)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John G. O'Connor, M. D.

19 (Address) South Fallo Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 16 1923

20 UNDERTAKER: Frank Brockson — ADDRESS: Walbrook Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73774

CERTIFICATE OF DEATH.

90 D73774

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 Hennenman Ave ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Gilmore

(a) RESIDENCE. No. 1924 Hennenman Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Gelmore

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Henry Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Andrew Gelmore

(Address) 1924 Hennenman Ave

Filed 4 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1923

17

I HEREBY CERTIFY, That I attended deceased from On March 10, 1923,

that I last saw h[illegible] alive on Mch 11, 1923,

and that death occurred, on the date stated above, at 5-50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

3-11 1923 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Evergreen Cemetery	March 15 1923
20 UNDERTAKER	ADDRESS
Chas G. Bailey	1421 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73775 HEALTH DEPARTMENT—CITY OF BALTIMORE D73775

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St., 16 Ward)

Registered No. C 188-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Sugars

(Residence in Baltimore: No. 1027 N. Carey St.; yrs. 3 mos. ds.)

THE CAUSE OF DEATH must be properly certified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M.	Col.	Married

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE. 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lab.
(b) General nature of industry, business, or establishment in which employed (or employer): Gen

9-BIRTHPLACE, (State or Country). W. Va.

PARENTS.

10-NAME OF FATHER. Thos. Sugars

11-BIRTHPLACE OF FATHER, (State or Country). W. Va

12-MAIDEN NAME OF MOTHER. McKinney

13-BIRTHPLACE OF MOTHER, (State or Country). W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Dan. Sugars

(Address) 1027 N. Carey

15- Robert P. Harrison,

Filed 1923 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. rib & left. side
Fract. Vertebra.
Fell from an auto - struck by another auto

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

March 14, 1923. (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn DATE OF BURIAL. March 15 1923

20-UNDERTAKER. Harman & Wyatt ADDRESS 649 N. Carey

Spec.—9-24-14—M. & T.—3000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73776

CERTIFICATE OF DEATH.

74-001 D73776

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 Patterson Place E. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. O'Farrell

(Residence in Baltimore: No. 1920 Patterson Place St.; about 40 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
male	White	Married

6-DATE OF BIRTH. December 5, 1860
(Month) (Day) (Year)

7-AGE. 60 yrs. 3 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Greenmount Cemetery

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. James O'Farrell

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Mary M.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M. Jones

(Address) 1920 Patterson Place

15-

Filed ..... Robert E. Harrison, Registrar.

1 4 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12, 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from February 22 1923, to March 12 1923, that I saw him alive on March 12 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 18 ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Albert O'Connell M.D.

March 13 1923 (Address) 3027 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery DATE OF BURIAL: Mch. 15, 1923

20-UNDERTAKER Geo. J. Pugh ADDRESS 1735 Hanford Ave

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D73777

CERTIFICATE OF DEATH.

D73774

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1909 N. Collington ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Rankin Folks

(Residence in Baltimore: No. 1909 N. Collington ave St.; 29 yrs., 1 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. m

4-COLOR OR RACE. W White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 13, 1923
(Month) (Day) (Year)

7-AGE, 29 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Wm. M. Folks.

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Mary A. Barranger

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis H. Folks

(Address) 1909 N. Collington ave

15-

Filed ....., 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

AR 14 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 9th 1923, to March 13 1923, that I saw h— alive on March 13 1923, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Blackburn Jr. M. D.

March 13 1923 (Address) 632 Gorsuch ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, 3/16/23 191...

20-UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hoffman

CAUSE OF DEATH to be plainly written. Every item must be properly answered. Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73778

CERTIFICATE OF DEATH.

38 D73778

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Eutaw Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Etta Mae Stedman

(a) RESIDENCE. NO. 1608 Eutaw Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 8-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	6	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Arthur G. Stedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mich.

12 MAIDEN NAME OF MOTHER Elsie Macgis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Arthur G. Stedman (Address) 1608 Eutaw Place

15 [illegible] 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

AR 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 14 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1923, to Mar 13, 1923, that I last saw her alive on Mar 13, 1923, and that death occurred, on the date stated above, at 6 AM m.

The CAUSE OF DEATH* was as follows:

Congenital Debility
Congenital Syphilis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) R Hills Hemming M. D.

3/14, 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cemetery	Mar. 15 1923
20 UNDERTAKER	ADDRESS
Elmer W. Conklin,	924 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D73779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73779

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1137 Argyle Ave. Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanora B. Hurst.

(Residence in Baltimore: No. 1137 Argyle ave. St.; 70 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Dec. (Month) 12 (Day), 1852 (Year)

7-AGE, 71 yrs. 3 mos. 0 da. If LESS than 1 day, ...hrs. or.....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Thomas Shay

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Margaret Toy

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hurst (Daughter)

(Address) 1137 Argyle Ave.

15- Mar. 14 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 2 1923, to Mar. 12 1923, that I saw h[er] alive on Mar. 12 1923, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 6 yrs. mos. da.

CONTRIBUTORY (Secondary) Ac. Pneumonia

(Duration) 9 yrs. mos. da.

(Signed) W. J. Campbell M. D.

Mar. 14 1923 (Address) 213 Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Mar. 15, 1923

20-UNDERTAKER Jno. M. Johnson — ADDRESS 1234 Eltings St.

Important. See instructions on back of certificate.

Spec.—8-24-24—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73780 D73780

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 N. Castle ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul McKay

(Residence in Baltimore: No. 1017 N. Castle St. St.; 52 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 30th, 1871
(Month) (Day) (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas McKay

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Bayne

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John McKay

(Address) Govans P.O. Baltimore

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

1 4 1923 Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 1 1923, to Mar 12 1923, that I saw him alive on Mar. 12 1923, and that death occurred, on the date stated above, at 1.15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm M Wright M. D.

Mar. 13 1923 (Address) 1801 St. Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, March 15, 1923

20-UNDERTAKER E A Windsheid Jr — ADDRESS 501 E 22 St

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73781

CERTIFICATE OF DEATH.

90 D73781

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 300 E 21st. ST.: 17 WARD)

2-FULL NAME Julia E. Shehan.

(a) RESIDENCE. No 300 E 21st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19th 1851

7 AGE: Years 65 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Camil Shehan.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Kelly.

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Ireland.

14 Informant: John Shehan. (Address) 300 E 21st St.

15 Filed 19 APR 14 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Mar 13, 1923, that I last saw her alive on Mar 12, 1923, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis
Myocarditis - acute
Dilatation Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 300 E 21st

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

Mar. 19 23 (Address) 116 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	March 16 1923
20 UNDERTAKER	ADDRESS
E. A. Wiedefeld Jr	501 N Gay St

Should be carefully supplied. ALL information should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73782

CERTIFICATE OF DEATH.

168 D73782

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 441 E. 25 St. W. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Cecelia McCardell

(Residence in Baltimore: No. 441 E. 25 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Single

6 DATE OF BIRTH: ....., 1897 (Month) (Day) (Year)

7 AGE: 25 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or Country): Balto.

PARENTS.

10 NAME OF FATHER: Ernest McCardell

11 BIRTHPLACE OF FATHER (State or Country): Balto.

12 MAIDEN NAME OF MOTHER: Bertie Brown

13 BIRTHPLACE OF MOTHER (State or Country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest McCardell.

(Address) 441 E. 25th St.

15

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

14 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 13, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation

Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Christ Pressly M. D.
(Coroner)

Nov 14, 1923 (Address) 3032 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: Nov. 15, 1923

20 UNDERTAKER: E. A. Windsor Jr. — ADDRESS: 601 E. 25 St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73783 ✓ 164 D73783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Norris

(a) RESIDENCE NO. Ray View Asylum. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown ?

6 DATE OF BIRTH (month, day, and year) 1818

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
104	?	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER ? unknown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Unknown

14 Informant Municipal Hospital Records.
(Address)

15 Robert P. Harrison,
Registrar

R 14 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 19 23

17

I HEREBY CERTIFY, That I attended deceased from March 7, 19 23, to March 13, 19 23,

that I last saw her alive on March 12, 19 23,

and that death occurred, on the date stated above, at 8:55 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ?, yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde [illegible] M. D.

3-13 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cmtry

DATE OF BURIAL 3/15/23

20 UNDERTAKER J Leon Hall

ADDRESS 1924 Dlan

mation should be carefully supplied. Exact statement of OC PA-
CAUSE OF DEATH in plain terms, so tha
TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73784

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-01 D73784

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 554 St. Mary Ct ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Almut Brown

(a) RESIDENCE. NO. 554 St. Mary Ct ST. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Harriet Helmolly

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 27 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Hoffman Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Josephine Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Mrs Harriet Henderson 554 St. Marys Ct.

15 Filed MAR 15 1923 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 7 1923, to Mar. 12 1923.

that I last saw him alive on Mar. 12 1923.

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

*Lobar Pneumonia-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) Wm Montgomery, M. D.

1923 Address) 1 W McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: March 15 1923

20 UNDERTAKER: Robert J. Williams — ADDRESS: 1511 McElderry St

TION is very important. See instructions on back of certificates.

...ATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

...be stated EXACTLY. PHYSICIANS should state

...Every item of infor-

Spec.—1-10-21—M&T—1500 Blks.

D73785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D73785

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 E. North Ave ST., 8 WARD)

2-FULL NAME George. H. Stempe

(a) RESIDENCE NO. 2089 E North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Sing'l

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 24 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Stempe

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known
(State or country)

14 Informant Mrs. Anna Reil
(Address) 2012 E North ave

15 FILED MAR 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1922, to March 13, 1923, that I last saw ~~was~~ alive on March 12, 1923 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John L. Boyd M. D.

(Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 16, 23
20 UNDERTAKER	ADDRESS
Henry Hoerle Sons	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D73786

D73786

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 Aisquith St. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Preller

(a) RESIDENCE NO. 1035 Aisquith St ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Preller

6 DATE OF BIRTH (month, day, and year) July 25 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Preller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Kartes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Barbara Preller

(Address) 1035 Aisquith St

15 Date Received MAR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1923

17 I HEREBY CERTIFY, That I attended deceased from March 4. 1923 to March 13. 1923

that I last saw him alive on March 13. 1923

and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. X. Schaub, M. D.

19 (Address) 1081 Aisquith Ste.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 17 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73787. HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 74-001 D73787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Eastern Ave & East Ave 15 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Gable

(Residence in Baltimore: No. 2442 E. North Ave St.; yrs. 64 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Oct 23rd (Month) (Day) 1858 (Year)

7-AGE: 71 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stone Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): 075

9-BIRTHPLACE, (State or Country): Phila, Pa

PARENTS.

10-NAME OF FATHER: — Gable

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Caroline Eichorn

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Franklin Gable
(Address) 2442 E. North ave

15-
Filed MAR 15 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: March 13 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to his death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy
Cerebral
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Thos. P. Hoffas M. D.
(Coroner)

March 14 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Basilar Fract

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	March 16 1923

20-UNDERTAKER, ADDRESS
Henry Houck & Son 1301 E. Eager st

Is CAUSE OF DEATH to be filled in plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73788 — 1-PLACE OF DEATH

CERTIFICATE OF DEATH.

22 159-002

D73788 — Registered No. C.....

City of BALTIMORE: (No. 702 Hanover St., St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... LeRoy F. Clough.

(Residence in Baltimore: No. 702 Hanover St. St.; yrs. mos. ds.)

--- 2 --- 11-

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. January 2, 1923.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
--- yrs. 2 mos. 11 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John M. Clough.

11-BIRTHPLACE OF FATHER, (State or Country). Kent Co. Md.

12-MAIDEN NAME OF MOTHER, Phoebe Wilson.

13-BIRTHPLACE OF MOTHER, (State or Country). Hartley Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Phoebe Clough. (mother).
(Address) 702 Hanover St.

15- FILED MAR 15 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13, 1923. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)
March 14, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross A.A. Co. Md.	Mar. 15 1923

20-UNDERTAKER.	ADDRESS
John F. Denny.	715 Light St

NOTICE—Undertaker is required to present this certificate to the Registrar of the district in which death occurred before a burial permit will be issued. See instructions on back of certificate. This is very important.

Spec.—1-10-21—M&T—1500 Blks.

D73789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D73789

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 408 S. Fourth St. (St.) Brooklyn (Ward) 25

2-FULL NAME George William Gischel

(a) RESIDENCE NO. 408 S Fourth St. (Usual place of abode) Brooklyn Ward

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Gischel

6 DATE OF BIRTH (month, day, and year) March 16 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 015

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER John H Gischel

11 BIRTHPLACE OF FATHER (city or town) Dont Know (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Wurty

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Catherine Gischel (Address) 408 S 4th St Brooklyn Md

15 Filed MAR 15 1923 19.... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1923, to Mar. 13th, 1923, that I last saw him alive on Mar. 10th, 1923, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination Insane

(Signed) William Scott, M. D.

Mar 14, 1923 (Address) 916 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Mar 16 1923
20 UNDERTAKER	ADDRESS
John F Denny	915 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73790

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D73790

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 So. Dallas St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carlena Jenkins

(Residence in Baltimore: No. 222 So. Dallas St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Sing'l

6-DATE OF BIRTH. July (Month) 15th (Day) 1922 (Year)

7-AGE. 0 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Thos. Jenkins

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Elizabeth Coates

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Jenkins

(Address) 222 So. Dallas St

15 MAR 15 1923 Filed 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 13th (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, and ....find that said deceased came to ....death (by autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. D. Horton M. D.
(Coroner.)

March 14 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Cedar Lawn DATE OF BURIAL. 3/15 1923

20-UNDERTAKER. Theodore White ADDRESS 113 S. Wolfe

If a case of violence, do not fill out this certificate, but notify the Coroner at once. Every question must be answered, or the certificate will be returned for correction. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73791 HEALTH DEPARTMENT—CITY OF BALTIMORE D73791

CERTIFICATE OF DEATH. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 N. Fulton Ave ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Waldman

(a) RESIDENCE NO. 531 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Waldman

6 DATE OF BIRTH (month, day, and year) Sept. 15-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	5	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Waldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mrs. Martha Waldman

(Address) 531 N. Fulton Ave.

15 Filed MAR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1923, to March 13, 1923.

that I last saw him alive on March 13, 1923.

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Vassalli, M. D.

, 19 (Address) 525 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL March 17-23.

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S Wolfe

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73792

CERTIFICATE OF DEATH.

74001

D73792

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 W. Fayette ST., 20 WARD)

2-FULL NAME Wilhelmina Wagner

(a) RESIDENCE NO. 2105 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Wagner.

6 DATE OF BIRTH (month, day, and year): Nov. 26-1851

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
71	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Emil Hetzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mont Rudis.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Katherine V. Wagner. (Address) 2105 W. Fayette St.

15 FILED MAR 15.1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14. 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 13. 1923 to Mch. 14. 1923.

that I last saw h[illegible] alive on Mch 13 1923,

and that death occurred, on the date stated above, at 5[illegible] A. m.,

The CAUSE OF DEATH* was as follows:

Super Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage,

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) 336 E. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: March 16 1923

20 UNDERTAKER: M. & Mrs. John H. Snyder & Son — ADDRESS: 811 W. Fayette

E should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. — 1-10-21 — M&T — 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73793

CERTIFICATE OF DEATH.

101-001

D73793

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S. Sharp, ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Freeman

(a) RESIDENCE NO. 317 S. Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Freeman

6 DATE OF BIRTH (month, day, and year) —— 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Maryland.

PARENTS

10 NAME OF FATHER Henry Freeman

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachael Jones.

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co, (State or country) Maryland.

14 Informant Annie Harris

(Address) Annie Arundel St

15 MAR 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar, 12, 1923, to Mar, 14, 1923, that I last saw him alive on Mar, 13, 1923, and that death occurred, on the date stated above, at 2 a, m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 6. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Davis Franklin M. D.

3/14, 1923 (Address) 1111 E. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	March 16 1923
20 UNDERTAKER	ADDRESS
W. L. Brown & Son	1810 Monday

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73794

CERTIFICATE OF DEATH.

100-001

D73794

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patience Thompson

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unk yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Abraham Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 Filed MAR 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 19 23

17

I HEREBY CERTIFY, That I attended deceased from March 6, 19 23, to March 13, 19 23, that I last saw h.. alive on March 12, 19 23, and that death occurred, on the date stated above, at 1:15 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Terminal)

seven days

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3-13-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Et

DATE OF BURIAL Mch 16 1923

20 UNDERTAKER L. E. Thompson Son

ADDRESS 1810 Monty

D73795

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73795

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1308 Vincent St ST. 15 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Scott

(Residence in Baltimore: No. 1308 Vincent St St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	married

6-DATE OF BIRTH, About (Month) (Day) 1886 (Year)

7-AGE, 37 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer,
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Daniel Scott

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Jane Nelson

13-BIRTHPLACE OF MOTHER (State or Country), Va,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Nelson

(Address) 2239 Brunt St.

15-

Filed MAR 15 1923 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Dr. T. J. Hennessy M. D. (Coroner.)

March 14, 1923 (Address) 2302 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn.	March 13 1923
20-UNDERTAKER	ADDRESS 1312 Eastern Ave.
John N. Lane	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D73796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73796

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3 Helen Louise Berry ST.: 15 WARD)

2-FULL NAME 1506 Freestander Sr.

(Residence in Baltimore: No. 1506 Freestander Sr. St.: yrs., 3 mos. 21 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	colored	single

6-DATE OF BIRTH, Nov. 23, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Sherman Berry

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Webster

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sherman Berry Sr.

(Address) 1506 Freestander Sr.

15- Filed MAR 15 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) pending find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ....yrs. ....mos. 1 4 ds.

CONTRIBUTORY (Secondary) no history.

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

March 14, 1923 (Address) 503 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	March 15 1923
20-UNDERTAKER James R Lewis	ADDRESS 1503 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73797

CERTIFICATE OF DEATH.

101-001

D73797

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2761 W. Fairmount ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mildred Drew Haupt

(a) Residence No. 2761 W. Fairmount St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 26, 1921

7-AGE, 2 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas. Haupt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Lucile Seiler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md

14- (Informant) Chas. Haupt

(Address) 2761 W. Fairmount Ave

15- FILED MAR 15 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 13, 23

17- I HEREBY CERTIFY, That I attended deceased from Mar. 5, 19 23 to Mar. 13, 19 23

that I last saw her alive on Mar. 13, 19 23

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D. [illegible], M. D.

(Address) 1006 Eutaw Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, Mar. 15, 1923

20-UNDERTAKER, Wm Cook — ADDRESS 507 E. Monument

In plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

D73798

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 N 25th St Balt Md ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Greenbury Brown

(a) RESIDENCE No. 116 N 25th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Eva Brown

6 DATE OF BIRTH (month, day, and year) Aug 17th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer) contractor 016

(c) Name of employer

9 BIRTHPLACE (city or town) Hookers Mills
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Brown

11 BIRTHPLACE OF FATHER (city or town) Westminster
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hydia Hoover

13 BIRTHPLACE OF MOTHER (city or town) Manchester
(State or country) Md.

14 Informant H. H. Brown
(Address) 116 West 25th St.

15 Filed MAR 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1921, to Mar. 13th, 1923, that I last saw him alive on Mar 13th, 1923, and that death occurred, on the date stated above, at 8.55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 15 mos 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emyr E Evans, M. D.

, 19 (Address) 2409 Mid-Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 16, 1923

20 UNDERTAKER ADDRESS

Wm Cook - 501 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73799

CERTIFICATE OF DEATH.

90 D73799

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence James

(a) RESIDENCE No. Tilghmans Island. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore, Md.

PARENTS

10 NAME OF FATHER William James

11 BIRTHPLACE OF FATHER (city or town) Eastern Shore, (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore, Md.

14 Informant Municipal Hospital Records.
(Address)

15 Filed MAR 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17

I HEREBY CERTIFY, That I attended deceased from February 23, 1923, to March 13, 1923, that I last saw him alive on March 13, 1923, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Brat Failure

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3-14 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tilghmans Talbot Co. Md.	March 16 1923
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73800 182 D73800

D73800

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Jackson Wharf foot of Bond St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha R. Reed

(Residence in Baltimore: No. 1507 E. Monument St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: about 57 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Desmond

(Address) 1507 E. Monument St.

15- MAR 15 1923 Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March 13 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and (autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. R. Horton M. D.
Coroner.
Mch 15 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Laurel

DATE OF BURIAL: Mch 15 1923

20-UNDERTAKER: R C Gross

ADDRESS: 1405 McElderry

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73801

CERTIFICATE OF DEATH.

90 D73801

Registered No.

1-PLACE OF DEATH

City of BALTIMORE, (No. 1416 Gorsuch ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel Rosa Carswell

(a) Residence No. 1416 Gorsuch ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Robert S. Carswell

6-DATE OF BIRTH (month, day and year) July 17 1846

7-AGE, 76 yrs. 7 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) England

PARENTS.

10-NAME OF FATHER Edward L Jackson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) England

12-MAIDEN NAME OF MOTHER Ann H. Powell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14- (Informant) Robert S. Carswell

(Address) 1417 Gorsuch ave

15- Filed MAR 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 14/23

17- I HEREBY CERTIFY, That I attended deceased from Mar 5, 1923, to Mar 14, 1923, that I last saw h[illegible] alive on March 13, 1923, and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm Pearce, M. D.

Mar 14 1923 (Address) 1-2 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount DATE OF BURIAL, Mch 16 1923

20-UNDERTAKER, John O'Mitchell ADDRESS 1211 W. Fayette St

instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73802 HEALTH DEPARTMENT—CITY OF BALTIMORE D73802

CERTIFICATE OF DEATH.

Registered No. 164

1-PLACE OF DEATH

City of BALTIMORE: (No. Sealing Sanatorium St., Norwood Heights 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Ann Tyson

(a) Residence No. 208 E. Lafayette Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 11 1846

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thomas Tyson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Cecil Co. Md

12-MAIDEN NAME OF MOTHER, Mary McCauley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Cecil Co Md

14- (Informant) Sadie E. Featherbury

(Address) 208 E. Lafayette Ave

15- Filed MAR 15 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 14 23

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1923 to March 13, 1923

that I last saw h. alive on March 13, 1923

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marshall B. Hirst M. D.

Mar 15 1923 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount DATE OF BURIAL, March 16 1923

20-UNDERTAKER. Jno O. Mitchell ADDRESS 1201 Lafayette

Instructions on back of certificates. Every Question Must Be Answered. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73803

CERTIFICATE OF DEATH.

129 D73803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 E Preston ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Carroll

(a) RESIDENCE NO. 1612 E. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~: Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND OF~~ (or) WIFE of: James H Carroll

6 DATE OF BIRTH (month, day, and year): Oct 5. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Thomas Carroll. (Address) 1612 E Preston st

15 Filed MAR 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13 1923

17

I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19... that I last saw h... alive on ... 19... and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Senility —

Chronic Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Influenza Edema

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? —

(Signed) ... M. D.

(Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 16 1923
20 UNDERTAKER	ADDRESS
Robt J Jones Inc	14 Doney

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Petrowska

D73804

HEALTH DEPARTMENT—CITY OF BALTIMORE

47 D73804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Fleet ST., 2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Santina Petrowska

(a) RESIDENCE NO. 1825 Fleet ST., 2 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 45; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Stefaniak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anton Petrowski

(Address) 1825 Fleet St

15 FILED MAR 15 1923 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1923

17 I HEREBY CERTIFY, That I attended deceased from February 27, 1923, to February 27, 1923, that I last saw h alive on February 27, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Fatal Coma

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No Test

(Signed) L. Swadish Jr, M. D.

(Address) 733 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Mar 17 19 23

20 UNDERTAKER: Mrs Frank Kowski — ADDRESS: 1618 Eastern

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73805

CERTIFICATE OF DEATH.

11-001

D73805

1-PLACE OF DEATH Inland Park Westport 25 REGISTERED NO. C.....

CITY OF BALTIMORE: (NO..... ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harrison B Miller

(Residence in Baltimore: No. Army Barracks West Port St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Married

6-DATE OF BIRTH, May (Month) 31 (Day) 1882. (Year)

7-AGE, 33 yrs. 10 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.S.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Simon Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER S. Meiler

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. Miller

(Address) 1721 N Pratt St

15-

FILED MAR 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 13 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-8 1923, to 3-13 1923, that I saw h[illegible] alive on 3-13-23 191..., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Double Bronchial Pneumonia

..... (Duration).....yrs.....mos. 4 ....ds.

CONTRIBUTORY (Secondary) Influenza

..... (Duration) .....yrs.....mos. 6 ....ds.

(Signed) Thos B Hall M. D.

3/14, 1923 (Address) Walbrook

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer	March 16, 1923
20-UNDERTAKER	ADDRESS
Mc-Mc[illegible] & S[illegible]	1737 N Pratt

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D73806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73806

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 21 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Sunderland

(a) RESIDENCE No. 884 Columbia Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER W. H. Sunderland

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Margaret Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Mr Sunderland
(Address) 884 Columbia Ave

15 MAR 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/23 19

17

I HEREBY CERTIFY, That I attended deceased from 3/12/23 19 to 3/14/23 19,
that I last saw him alive on 3/14/23, 19,
and that death occurred, on the date stated above, at 5.15 p. m.
The CAUSE OF DEATH* was as follows:

Diphtheria (Laryngeal)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Tracheotomy Date of 3/14/23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters

DATE OF BURIAL Mar 15 19

20 UNDERTAKER John J Fields

ADDRESS 1105 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D73807 HEALTH DEPARTMENT—CITY OF BALTIMORE D73807

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 Division St., 17 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Chandler

(Residence in Baltimore: No. 1336 Division St. 71 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M.	C.	Widower

6-DATE OF BIRTH, April 6, 1842
(Month) (Day) (Year)

7-AGE, 53 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H. Kinnamon

(Address) 1336 Davison Street.

15- MAR 15 1923 ROBERT R. KRAUTER, Filed....., 191.... Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 13, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 4 1923, to Mar. 7 1923, that I saw h[im] alive on Mar. 7 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema (Duration) yrs. mos. 8 ds.

(Signed) W. H. Carr M. D.

Mar. 14 1923 (Address) 5 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, Mar. 16, 1923

20-UNDERTAKER Mrs. R. A. Elliott — ADDRESS, 1317 Eutaw

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D73808

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 W. Biddle St.; 11 WARD) REGISTERED No. C 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Owen Thomas Johnson

(Residence in Baltimore: No. 118 W. Biddle St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, March 4, 1845
(Month) (Day) (Year)

7-AGE, 78 yrs. — mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Expressman

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Henry Johnson

11-BIRTHPLACE OF FATHER (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER Helen Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elliott

(Address) 1725 Ashland Ave

15- Filed MAR 15 1923, 191 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 6 1923, to March 13 1923, that I saw h[illegible] alive on March 12 1923, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis & Hypertension

(Duration) yrs. 3 mos. ds.

(Signed) R. J. Johnson M. D.

3/12, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cemetery — DATE OF BURIAL, Mar. 16, 1923

20-UNDERTAKER Mrs. R. E. Elliott — ADDRESS 1725 Ashland Ave

Important. See instructions on back of certificate. Statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

D73809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73809

CERTIFICATE OF DEATH.

154-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 Edmondson ave ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wesley Jewell

(a) RESIDENCE NO. 711 Edmondson ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 10- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Earl Jewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Thirmie Hilfrich

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Earl Jewell (Address) 711 Edmondson ave

15 MAR 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1923, to Mar 13, 1923, that I last saw h alive on Mar 13, 1923, and that death occurred, on the date stated above, at 5.0 P. m.

The CAUSE OF DEATH* was as follows:

Tetanus Forearm Osteo

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) Paul Brown, M. D.

3/14, 1923 (Address) 1837 Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 3-15-1923

20 UNDERTAKER H. C. Brannington

ADDRESS 517 N Silver st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D73810
1 PLACE OF DEATH

CERTIFICATE OF DEATH

161-001 D73810
REGISTERED NO. C.....

CITY OF BALTIMORE (No. 154 Dolphin ST.: 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Marcia Bowne.

(Residence in Baltimore: No. 154 Dolphin St.: — yrs. — mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March (Month) 10th (Day), 1923 (Year)

7 AGE: ..... yrs. ..... mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9 BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Thomas Allen

11 BIRTHPLACE OF FATHER (State or country): —

12 MAIDEN NAME OF MOTHER: Mabel G. Bowne

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mabel G. Bowne

(Address) 154 Dolphin

MAR 15 1923
Filed ....., 191.....

ROBERT R. KRAUTER,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 13th (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10th, 1923, to March 13th 1923, that I saw her alive on March 12th, 1923, and that death occurred, on the date stated above, at 0.30A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. — ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry C. Gale M. D.

March 14th, 1923. (Address) 240 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Cem. | DATE OF BURIAL: 3/15/23, 191.....

20 UNDERTAKER: John C. Bishop & Son | ADDRESS: 1107 Gilmor St.

Spec.—1-10-21 M&T 1500 Blks.

D73811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-007 D73811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Johnson

(a) RESIDENCE NO. 621 S Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Louis Pfeister

(Address) 721 N Eakewood ave

15 Filed 1923 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26' 1923, to Mar. 15 1923.

that I last saw him alive on Mar 15 1923,

and that death occurred, on the date stated above, at 10.30a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lung Abscess and Pleurisy etitis

over

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Feb. 25. 23.

Was there an autopsy? yes. deamage of gall Bladder

What test confirmed diagnosis? Post. Mortem

(Signed) Hiram Fried, M. D.

. 19 (Address) 913 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Mar 16 1923

20 UNDERTAKER John Ellis

ADDRESS 2008 Eleam

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73812

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Beck

(a) RESIDENCE NO. 529 S. Charles St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer 030

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John P. Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Stork

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address)

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17

I HEREBY CERTIFY, That I attended deceased from February 23. 1923. to March 13. 1923. that I last saw him alive on March 13. 1923. and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Grat Faieure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Mecray M. D.

3-13-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Mar 16 1923
20 UNDERTAKER	ADDRESS
F. H. Krause & Son	703 H

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73813

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hyddenham Hospital ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Snyder

(a) RESIDENCE NO. 928 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/10/19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER Abe Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Zelkow

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Jack Lewis (Address) 1439 E. Baltimore

15 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923, to March 15, 1923, that I last saw him alive on March 14, 1923, and that death occurred, on the date stated above, at 6:05 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? cultures (+)

(Signed) B. Krafow, M. D.

3/15/23 (Address) Hyddenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 3/15 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73814

CERTIFICATE OF DEATH.

X 41 D73814

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.. 13 WARD)

2-FULL NAME Irving H. Engler

(a) RESIDENCE NO. 2316 Whittier Ave. WARD New York N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 21 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark N. J.

PARENTS

10 NAME OF FATHER Rudolph Engler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie Rothstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1427 E. Baltimore St

15 Robert T. Harrison, Registrar
Burial Permit Clerk.

15 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITIONS and CAUSES is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15 1923

17

I HEREBY CERTIFY, That I attended deceased from March 5 1923, to March 15 1923.

that I last saw him alive on March 15 1923,

and that death occurred, on the date stated above, at 4.10 a m.

The CAUSE OF DEATH* was as follows:

General Septicemia

(due to Streptococcus Viridans

(duration) ... mos 15 ds. (?)

CONTRIBUTORY (Secondary) Bacterial Endocarditis

(duration) ... yrs. ... mos. 15 ds. (?)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Leonard H. Greenbaum M.D. 3/15 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City N.Y. DATE OF BURIAL 3/16 1923

20 UNDERTAKER Jack Lewis 1427 E Baltimore St ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1200 Brentwood Av. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William David Hoffer.

(a) RESIDENCE. No. 1200 Brentwood Av. ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Hewitt Hoffer.

6 DATE OF BIRTH (month, day, and year) Sept 10 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Operator

(b) General nature of industry, business, or establishment in which employed (or employer) R R

(c) Name of employer Western Maryland Railroad Co.

9 BIRTHPLACE (city or town) (State or country) Mercersburg Pa.

PARENTS

10 NAME OF FATHER David Benjamin Hoffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Shimpstown, not known Pa.

12 MAIDEN NAME OF MOTHER Rebecca Geeseman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Claylick, Pa.

14 Informant (Address) Mrs. Rebecca Hoffer Mercersburg Pa.

15 Filed MAR 15 1923 19 Robert F. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 26-1923 to March 13th 1923, that I last saw him alive on March 13th 1923, and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis;
Cirrhosis of Liver

(duration) ... yrs. ... mos. Past ... ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Malcolm Hirsh M. D.

, 19 (Address) 3000 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mercersburg Pa	March 16 1923
20 UNDERTAKER	ADDRESS
Wilbur N. Shuiver	1018 Edmondson Av.

THION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Alcoholic

Pneumonia 16

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73816

CERTIFICATE OF DEATH.

51 D73816

1-PLACE OF DEATH 4409 Reisterstown Rd. Registered No.....

City of BALTIMORE: (No. 4409 Reisterstown Rd St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth F. Barron

(a) Residence No. 4409 Reisterstown Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John Barron

6-DATE OF BIRTH (month, day and year): 2/24/1866

7-AGE: 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: John Allen

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Mary Leonard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14- (Informant): Mrs. J. Barron

(Address): 4409 Reisterstown Rd

15- Filed MAR 15 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 14 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 5, 1923, to March 14, 1923

that I last saw h[er] alive on March 14, 1923,

and that death occurred, on the date stated above, at 5 7 m.

The CAUSE OF DEATH* was as follows:

Diabetes

Uncx

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma + Pulmonary Edema (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thilton P. Hill, M. D.

, 19 (Address) Wylie ave & Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem't DATE OF BURIAL, March 16, 19

20-UNDERTAKER: William Cull Sons ADDRESS Baltimore

Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73817

CERTIFICATE OF DEATH.

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 63 Powell av

CITY OF BALTIMORE: (No. 63 Powell av ST., 26 WARD)

2-FULL NAME Annie E Reather

(a) RESIDENCE No. 63 Powell av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Charles F. Reather

6 DATE OF BIRTH (month, day, and year) Feb 7 - 1840.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	83.	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER John McCaffrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

14 Informant John W. Reather.

(Address) 63. Powell av

Filed MAR 15 1923 Robert P. Harrison, Registrar

Dr Webster Embalmed

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 10 1923 to March 14 1923.

that I last saw her alive on March 13 1923,

and that death occurred, on the date stated above, at 10 45 Am.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Albert Y. Webster, M. D.

19 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Mar 17 1923
20 UNDERTAKER	ADDRESS
Wm Cook & Son	6 North.

MAR. 15 1923.—WRITE mation sh CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73818

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D73818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4016 Rolandav ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jane L Jams

(a) RESIDENCE NO. 4016 Rolandav ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifte mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Jams

6 DATE OF BIRTH (month, day, and year) March 14-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Maryland

PARENTS

10 NAME OF FATHER Evans Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Margaret Poland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Miss. Ella Jams

(Address) 4016 Rolandav

15 Dec 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-4 1923 to 3-13 1923, that I last saw h.. alive on 3-13 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry C. Myers, M. D.

(Address) 3640 Rolandav

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns Ellicott City	March 16 23
20 UNDERTAKER Horace H. Burgee	ADDRESS 3631 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D73819

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D73819

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1034 Brentwood Av St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... John T Norton

(Residence in Baltimore: No. 1034 Brentwood St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. Dec 25 1859
(Month) (Day) (Year)

7-AGE. 63 yrs. 3 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)... Own

9-BIRTHPLACE, (State or Country). Balto, Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Anna Norton

(Address)... 1034 Brentwood Av

15-

Filed..... 192.....

Robert P. Harrison,

5 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Mar 14 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Nephritis Interstitial

(Duration)...yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary) Traumatic

(Duration)...yrs.....mos.....ds.

(Signed) James J. W Tenbrook M. D.
(Coroner.)

Mar 14 1923 (Address) 705 E Oliver St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Parkwood Cemetery	Mar 16, 1923

20-UNDERTAKER. Wm Leoff - 507 E Monument ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73820

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary George

(a) RESIDENCE. NO. White Marsh Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. George

6 DATE OF BIRTH (month, day, and year) April 12th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42		11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Messenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Reider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John E. George White Marsh Md.

15 [illegible] Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Febr 1923, to March 13, 1923, that I last saw h[illegible] alive on March 13, 1923, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia

Sore

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-8-23

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Leo. G. Wrang, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebenezer Cemetery	March 16 1923
20 UNDERTAKER	ADDRESS
Heath Leasehold Sons	Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 15 1923

75

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental Abortion
Operation for Cleaning
of Uterus

Spec.—1-10-21—M&T—1500 Bks.

D73821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73821

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3122 Montebello Ave 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester J. Schmuff.

(a) RESIDENCE NO. 3122 Montebello Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) 9/1/22

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Schmuff.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ada Kline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Ada Schmuff. (Address) 3122 Montebello Ave

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1923

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1923, to March 14, 1923,

that I last saw h alive on March 14, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

acute Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Theophilus Lee Jr M. D.

, 19 (Address) 632 Fairmount ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL 3/16/23

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hanford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73822

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D73822

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Harford ave. - 9 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Sachs

(a) RESIDENCE NO. 2314 Harford ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write~~ the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Albert Sachs

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annietta ...

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary Sachs
(Address) 2314 Harford Ave.

15 Filed Robert P. Harrison, Registrar
5 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from March 13, 19 23, to March 14, 19 23,
that I last saw h[illegible] alive on March 14, 19 23,
and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Louis Loth, M. D.

..., 19 ... (Address) 1101 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	3/17 1923
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73823

CERTIFICATE OF DEATH.

74-001

D73823

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2900 Weaver Ave ST., 27 WARD)

2-FULL NAME Wilhelmina P. Voneiff

(a) RESIDENCE No. 2900 Weaver Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~ John Weaver Sr.

6 DATE OF BIRTH (month, day, and year) May 1 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Voneiff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa Deter (Address) 2900 Weaver Ave.

15 Filed 1923 Robert E. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1923 to Mch 15 1923, that I last saw her alive on Mch 14 1923, and that death occurred, on the date stated above, at 12P m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 2 mos 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edna B Lemmon, M. D.

3 N, 1923 (Address) 918 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	3/18 1923
20 UNDERTAKER	ADDRESS 204
Philip Herwig	Orleans

87

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73824

D73824

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No 1505 N. Bond ST.: 8th (or WARD)

2-FULL NAME Mary Emrich

(a) RESIDENCE. No. 1505 N. Bond ST., WARD. Jarrettsville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? 82 yrs. 11 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Jacob Emrich

6 DATE OF BIRTH (month, day, and year) April 3 - 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jarrettsville Md.
(State or country)

PARENTS

10 NAME OF FATHER Anthony Baker

11 BIRTHPLACE OF FATHER (city or town) France
(State or country)

12 MAIDEN NAME OF MOTHER Victoria Hahn

13 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country)

14 Informant Chas. H. Emrich Jr.
(Address) 1505 N. Bond St.

15 Mar 15 1923 Robert E. Harrison
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Mar 15, 1923.

that I last saw h alive on Mar 15, 1923

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and
Endocarditis (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Decompensation (duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) Walter Thomas, M. D.

(Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harford Co. Md. Salem Church Cem.	Mar 17 1923

20 UNDERTAKER E. G. Hurtz & Son ADDRESS Jarrettsville Md

TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73825 X 129 D73825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Inf

CITY OF BALTIMORE: (No. 1426 N. Broadway ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Wm S. Carter

(a) RESIDENCE NO. 3906 McKinley St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Wash. D. C

Length of residence in city or town where death occurred ..... yrs. ..... mos. 27 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia B. Carter

6 DATE OF BIRTH (month, day, and year) Aug 11 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 63				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Age Research B of L.E.

(b) General nature of industry, business, or establishment in which employed (or employer) Brotherhood of Locomotive

(c) Name of employer Firemen + Engineemen

9 BIRTHPLACE (city or town) (State or country) on none Austin Texas

PARENTS

10 NAME OF FATHER on Mon Saml Carter

11 BIRTHPLACE OF FATHER (city or town) on none (State or country)

12 MAIDEN NAME OF MOTHER on none

13 BIRTHPLACE OF MOTHER (city or town) on none (State or country)

14 Informant Dir B. Roberts Bro. (Address) Cleveland Ohio

15 MAR 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1923, to March 15, 1923, that I last saw h.m. alive on March 15, 1923, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease, Chr. Cardiac
Arterio Sclerosis
Chronic Interstitial Nephritis

(duration) 1 yrs. — mos ..... ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Richard F. Cobbett, M. D.

, 19 (Address) C H D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL March 19 1923

20 UNDERTAKER Wm. J. Gichner & Son

ADDRESS 20th & Pennsylvania Ave

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73826

CERTIFICATE OF DEATH.

11-00

D73826

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1920½ Ettting St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Banks

(Residence in Baltimore: No. 1920½ Ettting St. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	widow

6-DATE OF BIRTH, about (Month) (Day), 1857 (Year)

7-AGE, 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 04

9-BIRTHPLACE, (State or Country), Ky.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Banks

(Address) 1920½ Ettting St.

15-

Filed MAR 16 1923, 191... ROBERT N. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) myocardial degeneration

(Duration) yrs. mos. 14 ds.

(Signed) J. T. Tennison M. D. (Coroner.)

March 14, 1923 (Address) 230 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	3/16 1923
20-UNDERTAKER James J. Handley	ADDRESS W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73827

CERTIFICATE OF DEATH.

114 D73827

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 568 St. Mary's St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry W. Clair

(Residence in Baltimore: No. 568 St. Mary's St. ST.; 40 yrs., mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, Feb. 24, 1883
(Month) (Day) (Year)

7-AGE, 40 yrs. mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Winslow Clair

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Hester Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Chase

(Address) 568 St. Mary's St.

15- MAR 16 1923, 191.....

ROBERT R. KRAUTER.
Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest~~ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Inquest~~ (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastroenteritis

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) C. V. Hennessy M. D.
(Coroner.)

March 15, 1923 (Address) 28 W. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem.	3/16 1923
20-UNDERTAKER	ADDRESS
Samuel Hensley & Bro.	1 W. Biddle

If not buried in Baltimore, give name of cemetery in which interment is to be made.

IMPORTANT.—Answer all questions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73828 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 139 D73828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 15

City of BALTIMORE: (No. Mercy Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Anderson

(a) Residence No. 1357 N. Carey St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Feb 5 1899

7-AGE: 24 yrs. 1 mos. 10 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 170

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Samuel Anderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Mary Land

12-MAIDEN NAME OF MOTHER: Essie Butler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Mary Land

14- (Informant): Samuel Anderson

(Address): 1357 N Carey St

15- MAR 16 1923 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 13

17- I HEREBY CERTIFY, That I attended deceased from ~~Feb~~ March 19 23 to March 15 19 23

that I last saw h. alive on March 15 19 23

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Uterus Fibroides

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebro Cerebellitis

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? Yes Date of 3-10-23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. J. Scarpa M. D.

3/19, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery | DATE OF BURIAL: 3/19 1923

20-UNDERTAKER: Frank Kemsley | ADDRESS: 11 Eddis

Instructions on back of certificates. Examination of OCCUPATION is very important. See

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73829 113 D73829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1070 Rabaug St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Reed Cook

(Residence in Baltimore: No. 1070 Rabaug St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word)
Male	Colored	Single

6-DATE OF BIRTH. Aug (Month) 27 (Day) 922 (Year)

7-AGE. ..... yrs. 6 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Eugene Cook

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Nellie Reed

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Wooden

(Address) 1070 Rabaug St

15-

Filed MAR 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 14 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) improper feeding

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W Fenton M. D. (Coroner.)

Mar 15 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem — DATE OF BURIAL. March 16th 1923

20-UNDERTAKER. A C Jones — ADDRESS 111 S. Gilmor

24

If any item of information should be carefully supplied. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73830

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

94-001

D73830

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME. John Zirl

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	S?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
61	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 MAR 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1923

17 I HEREBY CERTIFY, That I attended deceased from January 17, 1919, to March 14, 1923, that I last saw him alive on March 14, 1923, and that death occurred, on the date stated above, at 11:00 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) D. A. Mackay, M. D.

3-15-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL
Trinity Cem.	March 16 1923
20 UNDERTAKER	ADDRESS
A. Jones	1111 Gilmor st

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D73831

CERTIFICATE OF DEATH.

90 D73831

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Druid Hill Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Gray

(a) RESIDENCE NO. Aged men & women's Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Gray

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Inmate of Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nathaniel Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Gray

(Address) 1622 Druid Hill Ave

15 Filed MAR 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1923

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1923, to March 14, 1923

that I last saw her alive on March 14, 1923

and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. J. Shelley, M. D.

3/15, 1923 (Address) 1230 S. Hilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	3 16 1923
20 UNDERTAKER	ADDRESS 142 W. Pratt
Jno. W. Toadvine	

TION is very important. See instructions on back of certificates.

...ert may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D73832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D73832

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Sharp ST. 23 WARD)

2-FULL NAME Mary Elizabeth Spriddle

(a) RESIDENCE NO. 910 Sharp ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Joseph Spriddle

6 DATE OF BIRTH (month, day, and year): [illegible] 1878

7 AGE: Years 45 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Samuel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Jos. Spriddle

(Address) 910 Sharp St

15 Filed MAR 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15th 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1923, to Mar. 15th, 1923, that I last saw h[illegible] alive on Mar 14th, 1923, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pleurisy with Effusion

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Daniel A. Carroll, M. D.

3/15, 1923 (Address) 1700 W Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Mch 17, 1923

20 UNDERTAKER: Jno. A. Joadim

ADDRESS 1423 W Hill St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...ame if any be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is neeessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tubercular

Spec.—5-19-13—M. & T.—500 Bks.

D73833

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

D73833

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Washington Blvd ST.; 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Golitz

(Residence in Baltimore: No. 1401 Washington Blvd St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word): Single

6-DATE OF BIRTH: November 30, 1921 (Month) (Day) (Year)

7-AGE: 1 yrs. 3 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Bklyn. Jew.

PARENTS.

10-NAME OF FATHER: George Glitz

11-BIRTHPLACE OF FATHER (State or Country): Greece

12-MAIDEN NAME OF MOTHER: Helen Kotsones

13-BIRTHPLACE OF MOTHER (State or Country): Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): George Golitz

(Address): 1401 Washington Blvd.

15-

Filed MAR. 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: March 15, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 28 1923, to March 15 1923, that I saw h[illegible] alive on March 15 1923, and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Pertussis Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Empyema

(Duration) yrs. 2 mos. 12 ds.

(Signed) E. G. Horn M. D.

March 15, 1923. (Address) 811 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: 3-16, 1923

20-UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun Hollins

Important. See instructions on back of certificate.

Sec.—1-10-21—M&T—1500 Bks.

Littig

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73834

CERTIFICATE OF DEATH.

10

D73834

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 E Biddle ST., 8 WARD)

2-FULL NAME William N. Littig

(a) RESIDENCE NO. 1607 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? Ft. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret L. Littig

6 DATE OF BIRTH (month, day, and year) Nov 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Luther Littig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louise G. Littig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Margaret L Littig (Address) 1607 E Biddle St

15 MAR. 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1923

17

I HEREBY CERTIFY, That I attended deceased from March-14, 1923, to March-15, 1923,

that I last saw him alive on March-14, 1923,

and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion- Cardiac Dilatation

Chronic Myocarditis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Entero colitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination.

(Signed) William H. Schwartz, M. D.

19 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Mar 19 23
20 UNDERTAKER	ADDRESS
Henry Koch Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73835

CERTIFICATE OF DEATH.

31 D73835

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 576 Bloom Street ST. 14 WARD)

2-FULL NAME Mrs Alice Lee

(a) RESIDENCE NO. 576 Bloom St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: George A. Lee

6 DATE OF BIRTH (month, day, and year): Sept 25, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Island Md

PARENTS

10 NAME OF FATHER: Wm. H. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Charlotte —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: George A. Lee

(Address): 576 Bloom St.

15 MAR 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 15 19 23

17

I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1922, to March 15, 1923, that I last saw her alive on March 15, 1923 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B. C

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Mullen, M. D.

3/15, 1923 (Address) 1230 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kent Island Cemetery Md

DATE OF BURIAL: 3/16 1923

20 UNDERTAKER: James H. Dennis

ADDRESS 303 Fremont Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73836

CERTIFICATE OF DEATH.

199 D73836

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Catherine B. Baggerly

(Residence in Baltimore: No. 3801 Conduit ave St.; 10 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. June (Month) 21 (Day) 1890 (Year)

7-AGE. 33 yrs. 1 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Gerhadt Allen

11-BIRTHPLACE OF FATHER. (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Catherine Wick

13-BIRTHPLACE OF MOTHER. (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian Baldwin

(Address) 3801 Conduit ave

15-

FILED MAR 16 1923 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 15 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Self Induced Abortion

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) General Septicaemia

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) James M. Freeburn M. D. (Coroner)

Mar 16 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death ..... yrs. ..... mos. 20 ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 3801 Conduit Ave

Former or usual residence. "

19-PLACE OF BURIAL OR REMOVAL. St Marys Hampden DATE OF BURIAL. Mar 17 1923

20-UNDERTAKER. Chenoweth & Son ADDRESS 1 Chestnut ave

is very important. See instructions on back of certificate. Each statement of OCCUPATION

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73837

CERTIFICATE OF DEATH.

9 D73837

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 879 Rabory St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Brodis

(Residence in Baltimore: No. 879 Rabory St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed or Divorced (Write the word.) Sgle

6-DATE OF BIRTH, Don't Know (Month) (Day) 1 (Year)

7-AGE, ... yrs. 5 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), B Cuby

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, Martha Brodis

13-BIRTHPLACE OF MOTHER, (State or Country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Brodis

(Address) 879 Rabory St

15-

Filed MAR 16 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 13 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... C.....

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough

..... (Duration) ..... yrs. 4 mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

3-15 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
MW Cemetery	3-16-1923
20-UNDERTAKER,	ADDRESS
Daniel Carbon	Balto

is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73838

CERTIFICATE OF DEATH.

129 ✓ D73838

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Bertha Williams

(a) RESIDENCE No. 322 N. Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER W. F. Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER ~~Dont~~ Winston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Dont~~ Winston

14 Informant David Easton

(Address) 916 Pine ave

15 MAR 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 15, 1923, that I last saw her alive on March 15, 1923, and that death occurred, on the date stated above, at 6-15 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-19 1923
20 UNDERTAKER David Easton	ADDRESS 916 Pine ave

TION is very important. See instructions on back of certificates. ...art it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D73839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73839

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1503 N. Saratoga ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Williams

(a) RESIDENCE No. 1503 N. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: married

6 DATE OF BIRTH (month, day, and year): June 1893

7 AGE: 28 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

040

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: George N. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Julia merrit

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant (Address): Julia merrit 1503 N Saratoga St

15 MAR 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch. 9, 1923, to Mch. 14, 1923, that I last saw h[illegible] alive on Mch. 13, 1923 and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Both Lungs)

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. M. Drevall, M. D.

3/14. 1923 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mt auburn cemetery — DATE OF BURIAL: march 16 23

20 UNDERTAKER: John H Toadvin — ADDRESS: 142 N Hill St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73840 HEALTH DEPARTMENT—CITY OF BALTIMORE D73840

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes. Hosp. ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eugenia Pearson

(a) RESIDENCE NO. 700 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rudy Pearson

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Simmons

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Tubman

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Henry Simmons
(Address) 615 N. Carrollton ave

15 MAR 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 13, 1923, to Mar. 15, 1923,

that I last saw h alive on Mar. 15, 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Coma Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A. Kirkbride, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Mar 17, 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSES OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73841

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D73841

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1. So. Payson ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Richner

(a) RESIDENCE. No. 1. So. Payson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widowed.

5a If married, widowed, or divorced ~~HUSBAND OF~~ ~~WIFE OF~~ Wife of Charles Richner

6 DATE OF BIRTH (month, day, and year) June 24 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Leibig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Rosella~~ Margaretha Hohmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louise Rehbein

(Address) 210 E Eager St

15 [illegible] MAR 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1923 to Mar. 13 1923

that I last saw her alive on Mar. 13 1923

and that death occurred, on the date stated above, at 4.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) A. Keller Henning, M. D.

3/16, 1923 (Address) 2000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar. 17 1923

20 UNDERTAKER George L. Schwab ADDRESS 1101 Edk Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73842

D73842

CERTIFICATE OF DEATH.

8 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hosp[illegible] ST., 8 WARD)

2-FULL NAME Thomas Hogan

(a) RESIDENCE NO. 1629 E. Lanvale st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer) 617

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Hogan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hardesty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Hospital Records

(Address) M.C.H.

15 Filed MAR 16 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1923, to March 12, 1923, that I last saw him alive on March 12, 1923, and that death occurred, on the date stated above, at 4.25 p. m.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic pulmonary tuberculosis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard A. Delaplaine M. D.

3-12-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	3/16 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH is very important. See instructions on back of certificates. Exact statement of OCCUPATION must be given that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73843

CERTIFICATE OF DEATH.

X 44

D73843

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Howard C. Kelly Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Edgar L. Ferran

(a) RESIDENCE. NO. Eustis, Florida ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy M. Ferran

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER John Ferran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Harry M. Ferran
(Address) Eustis Fla.

15 Filed MAR 16 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8th, 1923, to March 15th, 1923, that I last saw h~~im~~ alive on March 15th, 1923, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus

— (duration) — yrs. 1½ mos. — ds.

CONTRIBUTORY (Secondary) — (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 10th 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Guy L. Cromwell M. D.

3/15 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eustis Florida	March 16 1923

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W. Fayette St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73844

CERTIFICATE OF DEATH.

X 100 001 D73844

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 789 N Mulberry ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard E. Foy

(a) RESIDENCE NO. 789 N Mulberry ST., WARD Sharons Pl.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/27/1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Spencerville
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Foy

11 BIRTHPLACE OF FATHER (city or town) Balto. City
(State or country)

12 MAIDEN NAME OF MOTHER Emma Whiteis

13 BIRTHPLACE OF MOTHER (city or town) Worthington Co Md
(State or country)

14 Informant Bessie Foy
(Address) 789 Mulberry St

15 Filed MAR 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/1923

17 I HEREBY CERTIFY, That I attended deceased from 3/6, 1923, to 3/13, 1923 that I last saw h[illegible]live on 3/12, 1923, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Bronchy-Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

, 19 (Address) 92 N Wood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: March 19 23

20 UNDERTAKER Wm. R. G. Ellis ADDRESS 172 N Carey

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- nay be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

Spec—12-23-21—E.B.R.S.—400 Bks.

B Liona Cadden

D73845

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D73845

1-PLACE OF DEATH

City of BALTIMORE: (No. 913 Park Ave St. 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Liona Cadden

(a) Residence No. 913 Park Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occured 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 16, 1848

7-AGE 74 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New Windsor Md

PARENTS.

10-NAME OF FATHER Samuel Elkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan Hanes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) Mrs Bessie Cadden

(Address) 913 Park Ave

15-

Filed MAR 16 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/16/23

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1922 to March 15th 1923

that I last saw h alive on Mar 15th 1923

and that death occurred, on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion from Cancer

(Duration) — yrs. — mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/2/22

Was there an autopsy? No

What test confirmed diagnosis? Microscopical exam

(Signed) H. G. Willis M. D.

, 19 (Address) 6 E Read St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Windsor Md — DATE OF BURIAL. 3/19/23

20-UNDERTAKER. Geo J Smith — ADDRESS 1532 Hollins Ave

instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73846

D73846

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Chesapeake Ave & 7th, St. Brooklyn 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Edward Russell.

(Residence in Baltimore: No. 1610 S.Charles St. St.; 47 yrs., 7 mos., 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. July 30, 1875. 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
47 yrs. 7 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 40

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. George Russell.

11-BIRTHPLACE OF FATHER, (State or Country). Delaware.

12-MAIDEN NAME OF MOTHER. Mary Hyson.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Russell.(wife).

(Address) 1610 S.Charles St.

MAR 16 1923 Filed ..... 19.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13, 1923. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry find that said deceased came to his death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

March 16 1923. (Address) 1017 S.Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	3/16/23 19....

20-UNDERTAKER.	ADDRESS
C. J. Fahey & Sons	318 Light St.

If very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

D7384 CERTIFICATE OF DEATH. D73847

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Goskins

(a) RESIDENCE NO. ..... Bayview Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant Hospital Records (Address)

15 Filed MAR 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/23 19

17 I HEREBY CERTIFY, That I attended deceased from 12/17/18, 19 ..... to 3/13/23, 19 .....,

that I last saw h[illegible] alive on 3/13/23, 19 .....,

and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Emphysema & Chronic Bronchitis

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) J. A. McKay, M. D.

, 19 (Address) Bayview Asylum Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL MAR 16 1923

20 UNDERTAKER ..... ADDRESS .....

Commissioner Health, [illegible] F. WOODALL.

CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D73848

1-PLACE OF DEATH D73848

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mike Dougherty

(a) RESIDENCE NO. 600 S. Register St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of Industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Record. (Address)

15 Filed MAR 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 19 23

17 I HEREBY CERTIFY, That I attended deceased from March 7, 19 23, to March 12, 19 23, that I last saw him alive on March 12, 19 23, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

3-12 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. per Wm. H. Woodall

ADDRESS MAR 16 1923

0816

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. D73849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73849

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Watson

(a) RESIDENCE NO. 1007 Salisbury Alley. ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk, Va.
(State or country)

PARENTS

10 NAME OF FATHER Erik Watson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Municipal Hospital Records.
(Address)

15 MAR 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1923, to March 13, 1923, that I last saw h alive on March 13, 1923, and that death occurred, on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH was as follows:

Labar Pneumonia c

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Empyema Left Side

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. A. McKay, M. D.

3-14-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health, per Wm. R. WEEDAL

ADDRESS MAR 16 19

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 12-23-21—E.B.R.S.—400 lbs. D73850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D73850

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Oliver.

(a) Residence No. 1920 Druid Hill Ave. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6-DATE OF BIRTH (month, day and year) ? 1861

7-AGE, 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14-

(Informant)

(Address)

15-Filed MAR 16 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 13 23

17-I HEREBY CERTIFY, That I attended deceased from Mar 5, 19 23 to Mar 13, 19 23

that I last saw h. alive on Mar 13, 19 23

and that death occurred, on the date stated above, at 5-24 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sign & Symptoms

(Signed) J. Preuss M. D.

, 19 (Address) Mercy Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL, ..., 19....

20-UNDERTAKER, Commissioner Health. ADDRESS MAR 16 1923

Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73851

CERTIFICATE OF DEATH.

D73851

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 W. Lombard ST.: 19 WARD)

2-FULL NAME Mrs. Mary Theresa Kolb.

(a) RESIDENCE. No. 1317 W. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Nicholas Kolb.

6 DATE OF BIRTH (month, day, and year) Dec 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56.	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City.

PARENTS

10 NAME OF FATHER Joseph Thalhammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Dull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Nicholas Kolb
(Address) 1317 W Lombard st

15 MAR 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to March 13, 1923, that I last saw her alive on March 13, 1923, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Expert consultants

(Signed) John C Bowers, M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	3/17/1923
20 UNDERTAKER	ADDRESS
George A Fulton & Son	Fayette

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 124 D73852

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Cor. Lombard & Green Sts. WARD 4)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Redden

(a) RESIDENCE No. 601 Market St. Denton Md. WARD Denton Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND~~ WIFE of Mr F A Redden.

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64 years	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 937

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER James Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Sarah Bounds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Hospital Records

(Address)

15 Filed ... 19 ... Registrar

16 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/7, 1923, to 3/16, 1923, that I last saw h[illegible] alive on 3/16, 1923, and that death occurred, on the date stated above, at 10:10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Denton Md.

Did an operation precede death? Yes Date of 3/8/23 Ruptured Gall Bladder

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests.

(Signed) Dr Kron Jordon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Denton Md

DATE OF BURIAL May 17 1923

20 UNDERTAKER Wilbur H Mason

ADDRESS 1618 Edmondson Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D73853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73853

CERTIFICATE OF DEATH.

185

REGISTERED NO.....

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. John & Lafayette ST.? 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Annie Devine

(a) RESIDENCE NO. 1937 Mt. Royal Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May , 18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 yrs.	9 mo.	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chamber-maid
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer Mrs. Burns — 1937 Mt. Royal Ave.

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER William Devine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER (unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Annie Sheehan
(Address) 1909 Mt. Royal ave.

15 1923 Robert P. Harrison, ..., 19 ..... Registrar
Burial Permit Clerk.

6

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1923, to March 15, 1923, that I last saw her alive on March, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.

(duration) ..... yrs. ..... mos. (corrected) ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of Feb 7, 1923
Was there an autopsy? No.
What test confirmed diagnosis? Autopsy examination
(Signed) Norman E. Bruckenbaum, M. D.
, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenbaum Cathedral Cem.	3/17 1923
20 UNDERTAKER J. G. Moran	ADDRESS 320 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73854

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 N. Colbert ST.; 11 WARD)

2-FULL NAME Mary E. Hammond

(a) RESIDENCE. NO. 1309 N. Calvert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Hammond

6 DATE OF BIRTH (month, day, and year) August 24 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marie McKenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Rea Keech
(Address) 1309 N. Calvert St.

15 1923 Robert P. Harrison, Registrar
. 19
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1923, to March 15, 1923, that I last saw h[illegible] alive on March 15, 1923 and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Endocarditis
Chronic Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

. 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	3/19 19[illegible]

20 UNDERTAKER W. P. Cook

ADDRESS 502 S. Wolfe

TION is very important. See instructions on b[illegible] ...ut it may be properly classified. Exact statement of OCCUPA-

Spec—12-23-21—E.B.R.S.—400 Bks.

√ Norton 888 N. Lombard

D73855

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D73855

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 Lemmon St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Speelman

(a) Residence No. 916 Lemmon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced (HUSBAND) of (or) WIFE of William Speelman

6-DATE OF BIRTH (month, day and year) ? ? ?

7-AGE, About 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work, At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Peter McGreary

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14-(Informant) Mrs Mamie Howard

(Address) 1265 Sergeant St

15-FILED 6 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3/14/23.

17-I HEREBY CERTIFY, That I attended deceased from March 11, 1923, to March 14, 1923, that I last saw h.. alive on March 14, 1923, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Old age.

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery DATE OF BURIAL, 3/17, 1923

20-UNDERTAKER, Wm Cook ADDRESS 502 E North Ave

INSTRUCTIONS ON BACK OF CERTIFICATES.

Spec.—1-10-21—MAT—1500 Blks.

16 D73856 Surg

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73856

X 159-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Delaney

(a) RESIDENCE NO. 384 Warren Ave Woodhaven. N.Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): July 26-1922

7 AGE — Years: — Months: 7 Days: 18 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N.Y.

PARENTS

10 NAME OF FATHER: Wm. J. Delaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

Filed 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 7-1923 to Mar. 16. 1923. that I last saw he alive on March 16-1923, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

CONTRIBUTORY (Secondary): Postoperative Shock (duration) yrs. 7 mos 18 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 14 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrille Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodhaven N.Y. DATE OF BURIAL 3/16 1923

20 UNDERTAKER: Albert L. Hilts Jr ADDRESS 1606 N Chester

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73857 D73857

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 McElderry ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mark Lacey Winfield

(a) RESIDENCE No. 1226 McElderry ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 COLOR OR RACE Male Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles winfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y. City

12 MAIDEN NAME OF MOTHER annie lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles winfield

(Address) 1226 McElderry St

15 3 16 1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 14 1923. to March 15, 1923.

that I last saw him alive on March 15. 1923,

and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) A L W Kennard, M. D.

3-16. 1923 (Address) 708 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodbury Cemetery

DATE OF BURIAL 17 March 1923

20 UNDERTAKER Edward Bryan

ADDRESS 1621 Orleans

TION is very important. See instructions on back of certificates.

Spec.-12-23-21-E.B.R.S.-400 Bks.

D73858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73858

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry F. Richardson

(a) Residence No. Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1863

7-AGE.	If LESS than 1 day,
59 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) D40

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country), unknown

11- (Informant) Municipal Hospital Records

(Address)

15- 1923 Robert J. Harrison Registrar.

6

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 13 19 23 to March 14 19 23

that I last saw him alive on March 14 19 23

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Path

(Signed) J. A. F. McCoy M. D.

3-15-, 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Laurel Cemetery	March 17, 19 23
20-UNDERTAKER.	ADDRESS
Chas. G. Bailey	772 Jefferson St

instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73859

CERTIFICATE OF DEATH.

X47

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Cora V. Snowden

(a) RESIDENCE NO. 30 N. 2nd St ST., WARD Harrisburg Pa.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 20, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): 109

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia

PARENTS

10 NAME OF FATHER: John Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Gertrude Ware

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Miss Edna Kugler
(Address): Philadelphia Pa

15 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-16 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-15-, 1922, to 3-16-, 1923.

that I last saw her alive on 3-16-, 1923,

and that death occurred, on the date stated above, at 1.55 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 3? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary metastasis

(duration) 3? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of (August 18th 1921)

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Karl Steinmueller, M. D.

3/16/1923 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Florida - Pa	March 26 1923
UNDERTAKER	ADDRESS
H. W. Jenkins & Son Co.	Gilbert Pa Colloh Pa

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73860

CERTIFICATE OF DEATH.

76 D73860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 W. Belvedere Ave (WARD) 27

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Frances L. Meyd

(Residence in Baltimore: No. 216 W. Belvedere Ave St.; 70 yrs., 6 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.)
Female	White	Married

6-DATE OF BIRTH. July (Month) 26 (Day), 1852 (Year)

7-AGE.	If LESS than 1 day,
70 yrs. 6 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, ~~V.~~ Held

11-BIRTHPLACE OF FATHER (State or Country), Europe

12-MAIDEN NAME OF MOTHER ~~W.~~ Swentzer

13-BIRTHPLACE OF MOTHER (State or Country), Europe

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John Meyd

(Address) 216 W. Belvedere Ave

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 15 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1921, to March 15 1923, that I saw her alive on March 14 1923, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

(a) Dementia Paralytica

(b) Cerebral Hemorrhage

(Duration) 1 yrs. 11 mos. 16 ds.

CONTRIBUTORY (Secondary) Trauma by Accident

from an accident (Duration) 1 yrs. 11 mos. 23 ds.

(Signed) Frances L. Carpenter M. D.

Mar 15, 1923 (Address) 201 Mt. Vernon Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	March 17, 1923
20-UNDERTAKER	**ADDRESS**
F. A. Strauss & Son	703 Hanover St

Important. See instructions on back of certificate.

Spec–12-23-21–E.B R.S.–400 Bks.

D73861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73861

CERTIFICATE OF DEATH.

100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 Belgian Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Lauthreimer

(a) Residence No. 711 Belgian Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 10 1921

7-AGE, 1 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm L. Lauthreimer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto.

12-MAIDEN NAME OF MOTHER, Margaret Hill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-

(Informant) Wm L. Lauthreimer

(Address) 711 Belgian Ave.

15-

Filed 1923

Robert F. Harrison,
192 Registrar.
Burial Permit Clerk.

Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mch 16 1923

I HEREBY CERTIFY, That I attended deceased from Jan. 20th, 1923, to Mch 16, 1923, that I last saw him alive on Mch 15th, 1923, and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Daniel J. & St. Thos Jenifer M. D.

Mch 16. 1923 (Address) Dowsdn. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Park mid. Dec 19, 1923

DATE OF BURIAL,

20-UNDERTAKER, Wm Cook

ADDRESS 202 E. 1st. Gve

Spec.—1-10-21—M&T—1500 Bks.

D73862 HEALTH DEPARTMENT—CITY OF BALTIMORE D73862

11-102

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 South Caca ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Freeman

(a) RESIDENCE NO. 602 South Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Freeman

6 DATE OF BIRTH (month, day, and year): April 23-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 03

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mary Sanders

(Address): 602 S. Paca St

15 16 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-16- 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to March 16, 1923, that I last saw h alive on March 16 1923 and that death occurred, on the date stated above, at 1115 A m.

The CAUSE OF DEATH* was as follows:

Acute Influenza

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Grip

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mitchell Braun, M. D.

, 19 (Address) 1129 West Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hayden

DATE OF BURIAL: 3 18 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 W Monte

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.P.S.–400 Bks.

Sister Mary Camilla
Mary Mc Ginnis ✓

D73863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73863

23

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sister Mary Carmeleta (?) Mary Mc Ginnis

(a) Residence No. Visitation Convent Park & Eutaw St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) ? ? 1869

7-AGE. 53 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Religious.
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Penna.

PARENTS.
10-NAME OF FATHER. James F. Williams
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Penna.
12-MAIDEN NAME OF MOTHER. Mary ?
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14- (Informant) Rev. Mother Miss Noonan
(Address) Visitation Convent.

15- MAR 17 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 15 '23

17- I HEREBY CERTIFY, That I attended deceased from March 13, 19 23 to March 15, 19 23 that I last saw h.. alive on March 15, 19 23 and that death occurred, on the date stated above, at 10 A.M. The CAUSE OF DEATH* was as follows:

Acute Encephalitis.

(Duration) ..., yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Respiratory failure (Duration) ... yrs. ... mos. 1 ds.

Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Post Mortem

(Signed) A. J. Buxedda M.D.
, 19 (Address) Mercy Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cem	Mar 17" 1923
20-UNDERTAKER.	ADDRESS 2236
Wm J Hartwell	W. Baltimore St

Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73864

CERTIFICATE OF DEATH.

43 D73864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. 16 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Annie E. McGowan

(a) RESIDENCE NO. 822 N. Carrollton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 27 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	-	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Bloomfield Perry Co. Penna

PARENTS

10 NAME OF FATHER: William C. McGowan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Miss Mary C. Robb Supt (Address) Presbyterian House of Md

15 3 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 1st, 1923, to Mar. 16th, 1923.

that I last saw her alive on Mar. 16th, 1923,

and that death occurred, on the date stated above, at 10.10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum.

(duration) 1 yrs. - mos - ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 3/9/23.

Was there an autopsy? Yes.

What test confirmed diagnosis? Laboratory.

(Signed) H. J. Bamberger M. D.

3/16 1923 (Address) 131 E. Woodland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: March 19 1923

UNDERTAKER: Chas. G. Block — ADDRESS: 742 W. North ave

MAY be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D73865

CERTIFICATE OF DEATH

31 D73865

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1615 Edmondson Ave WARD 14)

2 FULL NAME Mary Celeste Porter

(Residence in Baltimore: No. 1615 Edmondson Ave St. L. F. yrs. mos. ds.)

(If death occured a hospital or Institutio give its NAME Instead street and number an fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: July 4th, 1888 (Month) (Day) (Year)

7 AGE: 34 yrs. 8 mos. 12 ds. If LESS than 1 day, ... hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Library Bureau Co.

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Thomas Porter

11 BIRTHPLACE OF FATHER (State or country): Portsmouth, Va.

12 MAIDEN NAME OF MOTHER: Annie Daniels

13 BIRTHPLACE OF MOTHER (State or country): Wilmington, N. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin H. Porter

(Address) 1615 Edmondson Ave.

15 Filed ....., 191

Robert P. Harrison,
Burial Permit Clerk. REGISTRAR

1 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 16, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1922 to Mar 16 1923
that I saw her alive on Mar 16, 1923
and that death occurred, on the date stated above, at 7.46 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 7 mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis M Cochran Jr M. D.

Mar 16, 1923 (Address) 1505 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Mar 17, 1923

20 UNDERTAKER: Wilhamb[illegible] — ADDRESS: 502 E Madison

State CAUSE OF DEATH in plain terms, so that it may be correctly supplied. AGE should be stated EXACTLY. PHYSICIAN should is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D73866

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D73866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 So Fourth ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Maude Brown

(a) RESIDENCE NO. 405 So Fourth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred X yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): May 5-1922

7 AGE: Years 1922 | Months 10 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No

(b) General nature of industry, business, or establishment in which employed (or employer): No

(c) Name of employer: No

9 BIRTHPLACE (city or town) (State or country): Light and Lee Balto Md

PARENTS

10 NAME OF FATHER: Oscar Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): 405 So Fourth St

12 MAIDEN NAME OF MOTHER: Sadie Brehm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Oscar Brown 405 So Fourth St

17 1923 Robert P. Harrison, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 17 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to March 17, 1923, that I last saw her alive on March 16, 1923, and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) X yrs. X mos 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Town

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Jas L. Kinard, M. D.

19 22 (Address) 2486 3d

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Comel Cem — DATE OF BURIAL: Mar 19 1923

20 UNDERTAKER: John Mellis — ADDRESS: 2008 Aliceanna

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73867

CERTIFICATE OF DEATH

31 D73867

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 E Fayette St., 6 WARD)

2-FULL NAME Lena Jackson

(a) RESIDENCE NO 1528 E Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Color | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) ? 1910

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
13	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer not known.

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Edward Jackson

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant George Bell

(Address) 1528 E Fayette

15 Filed 1/7 1923 Robert F. Harrison, Registrar
. 19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 14, 1923, that I last saw h alive on March 13, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. ..... mos 14 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard L Parker M. D.

, 19 (Address) 1574 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Mem

DATE OF BURIAL 3/18 1923

20 UNDERTAKER R. L. Parker

ADDRESS 220 W Mulberry

TION is very important See instructions on back of certificate may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D73868

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D73868

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Green Spring & Rogers Ave. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sellards

(a) RESIDENCE NO. Green Spring & Rogers Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. ~ mos. 1 ds. How long in U. S., if of foreign birth? ~ yrs. ~ mos. ~ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 13- 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	~	~		30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Henry Sellards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Hannah Helen Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois.

14 Informant Father

(Address)

15 Nov 19 1923

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13 1923

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* was as follows:

Prematurity - non viable

5 months foetus.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John G. Murray Jr. M. D.

Nov 13- 19 (Address) 1107 St Paul Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carnegie Laboratory.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificates.

D73869 HEALTH DEPARTMENT—CITY OF BALTIMORE D73869

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St. ..... Ward) 7 X 179

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence ~~Spragins~~ Spragins

(Residence in Towson 203 Cheasepeake Ave. Towson, Md. St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
female	colored	single

6-DATE OF BIRTH. June 24/21 1.....
(Month) (Day) (Year)

7-AGE. 1 yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Shirley Spragins

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Florence Coleman

13-BIRTHPLACE OF MOTHER. (State or Country). Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Shirley Spragins

(Address) 203 Cheasapeake Ave. Towson Md.

15- Robert P. Garrison, Registrar.

7 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 15/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental-Tozemia due to 2nd & 3rd degree burns about face & scalp & body received when she put a celluloid comb in afire and her clothing caught fire.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] (Coroner) M. D.

3/17/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Pleasant Rest — DATE OF BURIAL. 3-17-1923

20-UNDERTAKER. Geo. H. Holland — ADDRESS 16 31 Hollins

If very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Dr Hemming. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73870 D73870

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2357 Fulton Ave ST., 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Temple

(a) RESIDENCE No. 2357 Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie E. Temple

6 DATE OF BIRTH (month, day, and year) Feb 14 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lathey

(b) General nature of industry, business, or establishment in which employed (or employer) Wm Kelly's 040

(c) Name of employer Levi Fadney

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew J. Temple

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Jennie E. Temple 2357 Fulton Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

7 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16-1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 3rd, 1922 to Mar 15, 1923, that I last saw him alive on Mar 15, 1923, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Hemophlegia. Chronic
Nephritis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) H Heller Hemming M. D.

3/17, 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmount Cemetery — DATE OF BURIAL: Mar 19, 1923

20 UNDERTAKER: F. B. Hesperd — ADDRESS: 2236 Fulton Ave

TION is very important. See instructions on back of certifica may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73871

CERTIFICATE OF DEATH.

57 D73871

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Bank ST., 3 WARD)

2-FULL NAME Margaret Albert.

(a) RESIDENCE NO. 1425 Bank ST., 3 WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~50~~ Lifetime yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Albert.

6 DATE OF BIRTH (month, day, and year) April 14/1851

7 AGE: Years 71 Months 1 Days 7

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Benhardt Sibommel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Gertrude Fredrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Albert 1425 Bank St.

(Address)

15 Filed 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1923, to Mar. 15, 1923, that I last saw her alive on Mar. 15, 1923, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Diabetes Mellitus

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis, hypostatic pneumonia, cerebral apoplexy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lab.

(Signed) Fred C. Rice, M. D.

, 19 (Address) 24 S Bilvay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetary

DATE OF BURIAL 19 Mar 19 20

20 UNDERTAKER: Davis Heeman

ADDRESS 32 S Broadway

CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D73872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 D73872

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3645 Belden Ave ST.: 12 WARD)

2-FULL NAME Ruth Naomi Forsyth

(a) RESIDENCE. No. 2416 Sisson ST., 12 WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 13/22

7 AGE: Years 9 Months Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fairmount Heights, Md

PARENTS

10 NAME OF FATHER: Wm L Forsyth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Edna A Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Wm L Forsyth 2416 Sisson St.

15 MAR 17 1923 19

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1922, to March 16, 1922, that I last saw h alive on March 15, 1922, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia,

(Secondary) (duration) indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. B. Normenut, M. D.

(Address) 3573 Chestnut Ave 3-16, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Marys Hampden — DATE OF BURIAL: March 17 1923

20 UNDERTAKER: Chenowith & Son — ADDRESS: Catonsville

Permit Clerk.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73873

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D73873

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 S. Lakewood ST., 1 WARD)

2-FULL NAME Teofil Kopycinski

(a) RESIDENCE NO. 625 S Lakewood ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Kopycinski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Kopycinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Adamkewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Agnes Kopycinski
(Address) 625 S Lakewood

15 Filed 7 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1923, to Mar. 15, 1923, that I last saw him alive on Mar. 15, 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Left Lung

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? X-ray + Laboratory

(Signed) Fred A. Rice, M. D.

3/16, 1923 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	3/19, 1923
UNDERTAKER	ADDRESS
William Kaczynski	Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73874

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73874

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 S. Becker Ave. WARD 1)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Rieker

(a) RESIDENCE NO. 712 S. Becker Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: John Rieker

6 DATE OF BIRTH (month, day, and year): Mar. 3/23

7 AGE — Years: 65 — Months: — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ind.

PARENTS

10 NAME OF FATHER: John Quissman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant: John Rieker (Address) 712 S. Becker Ave.

15 Filed , 19 Robert P. Harrison, Registrar

17 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan — , 19 22 , to March — , 19 23 , that I last saw h— alive on March 13 , 19 23 , and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Breast -

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Pulmonary - Metastasis

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 2 yrs. appx

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 125 S. Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem. — DATE OF BURIAL: 3/18 1923

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73875

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 East 34th. St. ST., 9 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret B. Long

(a) RESIDENCE No. 604 East 34th. Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fletcher Long

6 DATE OF BIRTH (month, day, and year) June 20 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wilson G. Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Annie M. Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Fletcher Long

(Address) 604 East 34th. St.

15 3 17 1923 Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1923

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to March 15, 1923, that I last saw h.. alive on March 13, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Mitral Dilatation of heart

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Wassermann test

(Signed) Ely Shreeve Jr. M. D.

, 19 (Address) 131 Garrison.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	3/17 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73876 ✓ D73876

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Katherine Molloy

(a) RESIDENCE. No. 2043 Kennedy Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis X. Molloy

6 DATE OF BIRTH (month, day, and year) July 8, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John F. Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Katharine Doory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant J. J. Molloy (Address) 604 E 34th St.

15 Filed 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 14., 1923. to March 16., 1923. that I last saw her alive on March 15, 1923. and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Hemolytic Streptococcus Septicaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No P.S. & S.

What test confirmed diagnosis?

(Signed) John J. Kluge, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/19 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

Augusta Wolf

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73877

CERTIFICATE OF DEATH.

129 D73877

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Hebrew Hospital Jackson ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Augusta Wolf

(a) RESIDENCE NO. Hebrew Hospital ST., Jackson WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Wolf

6 DATE OF BIRTH (month, day, and year) Sept. 23 1838

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hosp. Records. (Address)

15 3/17/1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923 to March 16, 1923, that I last saw her alive on March 16, 1923, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Arteriosclerosis

Hypertrophy, (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidore J. Fox, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 3/18/ 1923

20 UNDERTAKER Harry Sondheim

ADDRESS 118 W. Mt Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73878

CERTIFICATE OF DEATH.

100-00

D73878

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3047 W. North Av ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George N. Long

(a) RESIDENCE No. 3047 W. North Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? 79 yrs. 5 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mollie E Long

6 DATE OF BIRTH (month, day, and year) Oct. 18-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 013

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harmon Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mollie E. Long

(Address) 3047 W. North Ave

15 Filed R 17523 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March. 10, 1923, to March. 16, 1923, that I last saw him alive on March. 15, 1923, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Ellen, M. D.

3/16/23 (Address) 2757 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 19 1923
20 UNDERTAKER Henry A Ellen	ADDRESS 1744 W. North Ave

IMPORTANT—Exact statement of OCCUPATION may be properly classified. See that it may be properly classified, so that if many terms, so that if many terms, so that if many terms

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73879

CERTIFICATE OF DEATH.

31 D73879

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 Whittier Ave ST., 13 WARD)

2-FULL NAME Mayonne E. Whalen

(a) RESIDENCE No. 2364 Whittier Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

If may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Whalen

6 DATE OF BIRTH (month, day, and year): Sept 14 1890

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md.

PARENTS

10 NAME OF FATHER: Chas E. Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Florence Luck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: David E. Whalen
(Address): 2304 Whittier Ave.

15 Filed: Mar 17 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to Mar 16, 1923, that I last saw her alive on Mar 15, 1923, and that death occurred, on the date stated above, at 9 10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Abt (duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? don't know.

Did an operation precede death? no Date of. —

Was there an autopsy? —

What test confirmed diagnosis? X-Ray. Sputum

(Signed) Martin L Doan M. D.

3-16 1923 (Address) 414 S of. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Mar 19 1923

20 UNDERTAKER: Harry W. Ehlen — ADDRESS: 914 W. North Ave

Spec.—1-10-21—M&T—1500 Bks.

D73880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Tillmann

(a) RESIDENCE No. Rock Hall, Md ST., ... WARD Rock Hall Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 15 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Tillmann

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of Industry, business, or establishment in which employed (or employer) General. St

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rock Hall, Md.

PARENTS

10 NAME OF FATHER Adam Vintley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rock Hall, Md.

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rock Hall, Md.

14 Informant Franklin Sq Hospital (Address) Record

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-15-1923

17 I HEREBY CERTIFY, That I attended deceased from 2-25-, 1923, to 3-15-, 1923, that I last saw her alive on 3-15-, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute suppurative Thyroiditis

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 3-1-23

Was there an autopsy? No Thrombosis & Drainage

What test confirmed diagnosis? Histo-Path. examination

(Signed) Thomas E. Carr, M. D.

3/19, 1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hall Md — DATE OF BURIAL Mar 17 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73881

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D73881

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1106 W Fayette St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Householder

(Residence in Baltimore: No. 1434 Henry St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	Single

6-DATE OF BIRTH. Nov. (Month) 4 (Day) 1920 (Year)

7-AGE. 2 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER. Charles J Householder

11-BIRTHPLACE OF FATHER. (State or Country) Balto. Co. Md.

12-MAIDEN NAME OF MOTHER. Alma Cable

13-BIRTHPLACE OF MOTHER. (State or Country) Annundale Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father Charles J Householder

(Address) 1434 Henry St

15- Filed MAR 17 1923 192.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 13 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Embolism
Coronary artery
Sudden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

Mar 17 1923 (Address) 700 E Lanvale St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	3/19/23 19
20-UNDERTAKER.	ADDRESS
E H Conklin	924 E Lanvale St

R is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73882 ✓ X 131 D73882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Breitwieser

(a) RESIDENCE NO. Westminister, Md. ST., ... WARD Westminster Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 1 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Minnie S. Breitwieser

6 DATE OF BIRTH (month, day, and year) 1885.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Chas. L. Breitwieser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Nevia Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Self.

(Address) Camden md.

15 Filed MAR 17 1923 19.. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH:

16 DATE OF DEATH (month, day, and year) 3/16 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to March 16, 1923.

that I last saw him alive on March 16, 1923.,

and that death occurred, on the date stated above, at 9.55 a. m.

The CAUSE OF DEATH* was as follows:

Pyo-nephrosis.

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 3/15/23.

Nephrectomy

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Willis Crumpton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gamber Cemetery	March 19 1923
20 UNDERTAKER W M Routson	ADDRESS 2235 N Milton

Burial Permit Clerk.

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D73883

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D73883

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Farrant

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town nnd State)

Length of residence in city or town where death occurred 57 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Farrant

6 DATE OF BIRTH (month, day, nnd year) 1803

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) not Known Ireland

PARENTS

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (city or town) Castle Bridge (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget McCafe

13 BIRTHPLACE OF MOTHER (city or town) not Known (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed 1 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, dny, and year) March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to March 16, 1923, that I last saw h.. alive on March 15, 1923, nnd that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chr Nephr (Valv) Disease of Heart with Cerebral Arteriosclerosis

abt (durntion) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Psychosis - Senile -

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flanning, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means nnd Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additionnl space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	March 19 1923

20 UNDERTAKER Martin Bailey Co ADDRESS 627 W North

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D73884

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D73884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Druid Hill Av ST.: 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anne Eliza Butler

(Residence in Baltimore: No. 2023 Druid Hill Ave St.: 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb 1, 1837
(Month) (Day) (Year)

7-AGE, 86 yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Eugenia Busse

(Address) 2023 Druid Hill Ave

15-

Filed....., 191.....

Robert P. Harrison,
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1923, to March 16 1923, that I saw h Er alive on March 16 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Mural Arteio Sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H S McCard M. D.

3/17, 1923 (Address) 2001 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, 3-20, 1923

20-UNDERTAKER Geo H Holland

ADDRESS 1630 Druid Hill Ave

important. See instructions on back of certificate.

7 1323

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73885

CERTIFICATE OF DEATH.

90 D73885

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 S. Potomac ST., 1 WARD)

2-FULL NAME Barbara Oechsler.

(a) RESIDENCE NO. 1101 S. Potomac ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Oechsler

6 DATE OF BIRTH (month, day, and year) Mch 9th 1830

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
93		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Trauenholz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Katharine Oechsler (daughter)
(Address) 1101 S. Potomac St.

15 Filed ....., 19.... Robert P. Harrison, Registrar
7 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to March 15, 1923, that I last saw h[illegible] alive on Mch 14, 1923 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

3/17, 1923 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL Mch 19th 1923

20 UNDERTAKER Lilly + Zeiler — ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73886

CERTIFICATE OF DEATH.

100-001 D73886

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 Parrish ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Webb

(a) RESIDENCE NO. 1436 Parrish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 2/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Ollie Webb

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Lottie Tasker

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Lottie Webb
(Address) 1436 Parrish St

15 Filed 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 5, 1923, to Mar 15, 1923, that I last saw him alive on Mar 14, 1923, and that death occurred, on the date stated above, at 8-05 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

3/15, 1923 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Mar 17 1923

20 UNDERTAKER Jas. M. Johnson

ADDRESS 1234 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

~~3887~~ D73887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D73887

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Parish ST., 15 WARD)

2-FULL NAME Preston Brown

(a) RESIDENCE No. 1310 Parish ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Jena Brown

6 DATE OF BIRTH (month, day, and year) April ? 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) South (State or country) Carolina

12 MAIDEN NAME OF MOTHER Kate McDaniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Kate Brown

(Address) 1310 Parish St

15 MAR 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 6, 1923, to Mar 14, 1923, that I last saw ~~him~~ alive on Mar 13, 1923 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 9 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. William Frey, M. D.

3/17. 1923 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union. [illegible]	Mar. 18 1923

20 UNDERTAKER James N. Dent ADDRESS 302 Fremont

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73888

CERTIFICATE OF DEATH.

57 D73888

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 N. Gay ST., 8 WARD)

2-FULL NAME Sadie E. Eastwood

(a) RESIDENCE NO. 1123 N. Gay ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William Eastwood

6 DATE OF BIRTH (month, day, and year) Feb 12 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	63	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Joseph Vaughan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Lavinia White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs E. Eastwood (Address) 1123 N. Gay St

15 Filed MAR 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 28, 1923, to Mar 15 1923, that I last saw h e alive on March 15 1923 and that death occurred, on the date stated above, at 11,05 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hallie W White Jr M. D.

3/16, 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	March 18 23
20 UNDERTAKER	ADDRESS
Henry Lutz	W. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73889

CERTIFICATE OF DEATH.

101-001 D73889

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 810 N. Mount ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Burton

(a) RESIDENCE NO. 812 N. Mount ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Burton

6 DATE OF BIRTH (month, day and year) Sept 6 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 162

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Sarah Spedden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Wm H Burton Jr

(Address) 1021 N. Bond St

15 MAR 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1923, to March 16, 1923, that I last saw him alive on March 15, 1923, and that death occurred, on the date stated above, at 8.25 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Chas L. Dr. Rahe M. D.

3/16, 1923 (Address) 900 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	March 19 1923
20 UNDERTAKER	ADDRESS 1203
Henry Lutz	N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73890

CERTIFICATE OF DEATH.

135

D73890

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Peppler

(a) Residence No. 2428 E. Baltimore St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1854

7-AGE.	If LESS than 1 day.
68 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): 0

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS:

10-NAME OF FATHER. Balster Peppler

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Volkes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 18 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 16, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 6, 19 23, to March 16, 19 23, that I last saw him alive on March 16, 19 23, and that death occurred, on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Prostatic Obstruction

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. A. Luckett M. D.

3-17-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cross Cem Baltimore Co	3-19 1923

20-UNDERTAKER. F. B. Hale

ADDRESS 115 E. West St

Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73891

CERTIFICATE OF DEATH.

164 D73891

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Edmondson Av. WARD 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ann Jones

(a) RESIDENCE. No. 1804 Edmondson Av. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ ~~(HUSBAND)~~ of (or) WIFE of J. W. Jones

6 DATE OF BIRTH (month, day, and year) July 21. 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER John M. Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Leah Ann Paul

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Paul Thiele

(Address) 1804 Edmondson av

15 Filed MAR 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1923 to March 17 1923, that I last saw h~~e~~r alive on March 17 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. H. Wiseman M. D.

MAR 17 1923 (Address) 1330 N Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: MAR 19 1923

20 UNDERTAKER: Geo W Little — ADDRESS: 2700 EDMONDSON AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

171 D73892

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James C. Brown

(Residence in Baltimore: No. 1731 Aisquith St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, Divorced. (Write the word.)
male	white	widowed

6-DATE OF BIRTH. Feb 12/1853 (Month) (Day) (Year)

7-AGE. 70 yrs. 1 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Farmer

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Andrew J. Brown

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Miles Anne Mitten

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F.J.Reese

(Address) Westminster, Md.

15- MAR 18 1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 17/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia- following attempt at suicide by cutting throat and wrists on Mar. 3/23

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J S A Fallon M. D. (Coroner.)

3/18/23 192.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Melvin Branch Cemetery DATE OF BURIAL. March 19, 1923

20-UNDERTAKER. W M Routson ADDRESS R 23 E North

IS very important. See instructions on back of certificate. Exact statement of OCCUPATION may be property classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73893

CERTIFICATE OF DEATH.

90 D73893

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 E. 28th St., 9 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Mooney.

(a) RESIDENCE NO. 1922 E 28th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Mooney

6 DATE OF BIRTH (month, day, and year) May 27th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	72	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lotter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Gipple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Rosina Mooney (Address) 1922 E. 28th St.

15 Filed MAR 18 1923, 19... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17th 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 17, 1923; that I last saw her alive on March 11, 1923; and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurg. + Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Congestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas F. Blake, M. D.

3/17/1923 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	March 19th 1923
20 UNDERTAKER	ADDRESS
J. Bertram Lowe	1923 N. Gay St.

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73894

CERTIFICATE OF DEATH. X 161-007

D73894

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 394 E. FRANKLIN AVE. ST., GARDENVILLE 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ALBERTA B. RAAB

(a) RESIDENCE NO. OLD HARFORD ROAD PARKVILLE ST., ... WARD ..... Parkville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) DEC. 24 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWORK

(b) General nature of industry, business, or establishment in which employed (or employer) AT HOME

(c) Name of employer

9 BIRTHPLACE (city or town) PARKVILLE (State or country) MARYLAND

PARENTS

10 NAME OF FATHER JOHN A. RAAB

11 BIRTHPLACE OF FATHER (city or town) BALTO. CO. (State or country) MARYLAND

12 MAIDEN NAME OF MOTHER ALBERTA B. HARPLE

13 BIRTHPLACE OF MOTHER (city or town) BALTO. (State or country) Maryland

14 Informant (Address) JOHN A. RAAB PARKVILLE MARYLAND

15 FILED MAR 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MARCH 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 6, 1923, to Mch 16, 1923, that I last saw h[illegible] alive on Mch 16, 1923, and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Rt Lobar Pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

3/17 1923 (Address) Hamilton, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
ST. JOSEPHS CEMETERY	MARCH 19 19 23
20 UNDERTAKER Fredk Lassahn & Sons	ADDRESS FULLERTON MD.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D73895

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D73895

CERTIFICATE OF DEATH Hamilton

1-PLACE OF DEATH

City of BALTIMORE: (No. 311 Birchwood St., 37 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Marie Hillmyer

(a) Residence No. 311 Birchwood St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-If married, widowed, or divorced (Write the word) Single

HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 5-1922

7-AGE, ... yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frederic C. Hillmyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Helen E. Schwaninger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Frederic Hillmyer

(Address) 311 Birchwood Ave

15- MAR 18 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-17-23

17- I HEREBY CERTIFY, That I attended deceased from Feb 27, 1923 to March 17, 1923

that I last saw h.. alive on March 15, 1923

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Exhaustion - Toxaemia

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

.....(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Emmons, M. D.

Mar 19, 1923 (Address) 470 N Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer	3/19, 1923
20-UNDERTAKER, Wm Cook	ADDRESS 502 E North

Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73896

CERTIFICATE OF DEATH.

100-001 D73896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 N. Spring St.; 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Olive Brown

(Residence in Baltimore: No. 1817 N Spring St.; life yrs. mos. ds.)

Important. See instructions on back of certificate. If OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH: Sep 8, 1922 (Month) (Day) (Year)

7-AGE: 0 yrs. 6 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE (State or Country): Balto "md

PARENTS.

10-NAME OF FATHER: Edward Brown

11-BIRTHPLACE OF FATHER (State or Country): W Virginia

12-MAIDEN NAME OF MOTHER: Lillian Withers

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lillian Withers

(Address) 1817 N. Spring st.

15- MAR 18 1923 191.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, MARCH 17, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16 1923, to March 17 1923, that I saw her alive on March 17 1923, and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Status modicus Convulsions

Probable Causing Agents

Dilatation (Duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) X yrs. X mos. 7 ds.

(Signed) C. H. Dukes M. D.

March 17 1923 (Address) 928 E North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Country. DATE OF BURIAL: March 19, 1923

20-UNDERTAKER: Geo. J. Ruth ADDRESS: 1735 Harford ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73897

CERTIFICATE OF DEATH.

129 D73897

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Reisterstown Rd. ST., 19 WARD)

2-FULL NAME Moses S. Kuff

(a) RESIDENCE NO. 3704 Reisterstown Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Esther Kuff

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	—	—	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ephrain Kuff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sara Etta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto St

15 MAR 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to March 16, 1923, that I last saw h in alive on March 16, 1923, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy - followed by Paralysis and death

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Hypertension (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine - and Blood Pressure

(Signed) Joseph William Kelly, M. D.

, 19 (Address) 2327 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrem Washington Blvd	3/18 1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73898

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73898

CERTIFICATE OF DEATH.

1888-803

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 711 E. P. St. 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Bella Feailman

(Residence in Baltimore: No. 2288 N. Virginia Ave St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, March 1, 1890
(Month) (Day) (Year)

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Ely Adler

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Emma Rottgeser

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltimore St

15- Filed NOV 18 1923, 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit Given.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 16 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of pelvis, ribs
& L. Leg, about 5 minutes
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) automobile accident
(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)
March 20 1923 (Address) 2502 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship Cem. DATE OF BURIAL, 3-18-23

20-UNDERTAKER Jack Lewis ADDRESS 1439 Eastern Ave

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D73899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73899

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 H & Lnf Ward) St., 12

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Lipsitz

(Residence in Baltimore: No. 3405 Mortis Ave St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Aug 1 1920 (Month) (Day) (Year)

7-AGE. 2 yrs. 7 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Myers Stulman

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Annie Rosenberg

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1439 E. Balto.

15- Filed MAR 18 1923, 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Mar. 17 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull.

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Edw Blades M.D.

(Coroner)

(Address) 432 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Highview Friendship Cem. DATE OF BURIAL. 3-18 1923

20-UNDERTAKER. ADDRESS

Jac Lewis, 1439 E. Balto. St.

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D73900

D73900 CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 841 Hamilton Terrace ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bray

(a) RESIDENCE NO. 841 Hamilton Terrace ST. 11 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 58 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John B Bray

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Town of Golden
(State or country) Ireland

PARENTS

10 NAME OF FATHER Edmund Horan

11 BIRTHPLACE OF FATHER (city or town) Golden
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Johanna Lubey

13 BIRTHPLACE OF MOTHER (city or town) Golden
(State or country) Ireland

14 Informant Mrs. Anna B. Boyd (daughter)
(Address) 841 Hamilton Terrace

15 MAR 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 24, 1923, to Mar 16, 1923, that I last saw her alive on Mar 14, 1923, and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pelteham, M. D.

, 19 (Address) 817 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
New Cathedral Cemetery

DATE OF BURIAL
Mar-19-23

20 UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS
108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73901

CERTIFICATE OF DEATH.

101-001 D73901

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Cordelia Hopkins

(a) Residence No. 923 Poplar Grove St., Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? 65 yrs. 4 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Nov. 8 1857.

7-AGE, 65 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Hopkins

11-BIRTHPLACE OF FATHER (city or town) Fredericksburg (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Nancy Ryder

13-BIRTHPLACE OF MOTHER (city or town) Petersburg (State or Country), Va.

14-(Informant) Mr. Thos. J. Morton (Cousin)
(Address) 2729 N. Calvert St

15-FILED MAR. 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17 '23

17-I HEREBY CERTIFY, That I attended deceased from March 15 '23 2:35 P.M. to March 17 1923 4:30 P.M.

that I last saw her alive on March 17 19 23

and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ....yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ....yrs. ....mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Typical Signs

(Signed) L. J. Frangos M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, March 19 '23

20-UNDERTAKER, Stewart & Company — ADDRESS 108 W. North Ave

Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73902

CERTIFICATE OF DEATH.

100-001 D73902

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2517 Barclay ST., 12 WARD)

2-FULL NAME Mary J. B. Griffith

(a) RESIDENCE NO. 2517 Barclay ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mortimer C. Griffith

6 DATE OF BIRTH (month, day, and year): Feb. 21 1840

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
83	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Saml. Carnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Rebecca Woodall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Mary Mallalieu

(Address): 2517 Barclay St

15 Filed MAR 18 1923 ROBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 17 1923

17

I HEREBY CERTIFY, That I attended deceased from March 15th 1923 to March 17th 1923.

that I last saw h[illegible] alive on March 16th 1923.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Primary Bronchis Pneumonia

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. A. Fair M. D.

3/17/1923 (Address) 1126 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: Mar 19 1923

20 UNDERTAKER: Wm Fickner Sons

ADDRESS: North Ave

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73903

D73903

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Elm Hurst Rd ST., Roland Park WARD)

2-FULL NAME Martha Burroughs Orrick

(a) RESIDENCE NO. 5 Elm Hurst Rd Roland Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of H. W. Orrick

6 DATE OF BIRTH (month, day, and year) Nov 28th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	67	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Samuel Severing

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Victory Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: H. A. Orrick Jr
(Address) 5 Elm Hurst Rd Roland Park

15 MAR 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Mch 15th, 1923, to March 18th, 1923, that I last saw her alive on March 18th, 1923, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

INFLUENZA {with Pleurisy
Lobar Pneumonia}

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L Shearer, M. D.

, 19 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Can

DATE OF BURIAL Mar 20 1923

20 UNDERTAKER Henry W Jenkins & Son

ADDRESS Cathedral & Collins

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73904

D73904

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST., 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert M Klear.

(a) RESIDENCE NO. 1260 Battery Ave ST., 74 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER Mary Merryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant [illegible]

(Address) 1260 Battery

15 FILED MAR 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1923, to March 16, 1923, that I last saw him alive on March 16, 1923, and that death occurred, on the date stated above, at 12.40 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 12 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 2/28/23

Did an operation precede death? Yes Date of 3/8/23 Uremia + Drainage of Carbuncle

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John McCann, M. D.

19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3/19 1923

20 UNDERTAKER [illegible]

ADDRESS 518 Cathedral

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

73905
D73905

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73905

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 313 E North Ave ST., (17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma J. Golden

(a) RESIDENCE. NO. 313 E North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widow

6a If ~~married~~, widowed, or divorced (or) WIFE of: John Golden

6 DATE OF BIRTH (month, day, and year): Jan 16, 1866

7 AGE: Years 57 Months 2 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Housewife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Nehlon Flaxman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Elizabeth Brannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): E. Flaxman (Brother) 313 E North Ave

15 Filed MAR 19 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1916 to March 16, 1923.

that I last saw her alive on March 16, 1923.

and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
(Acute dilatation)

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic valvular disease of heart

(duration) many yrs. mos. d.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual physical examination

(Signed) Edwin Street, M. D.

, 19 (Address) 717 Park Ave Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 19 23
20 UNDERTAKER	ADDRESS
E. A. Wendefeldt	501 E 25th

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...ther may be properly classified. ...ons, or ...

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73906

CERTIFICATE OF DEATH.

33 D73906

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. 327 Gwynn Ave ST., 20 WARD)

2-FULL NAME Rosa A Mc Kenna

(a) RESIDENCE No. 327 Gwynn Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph V. Mc Kenna

6 DATE OF BIRTH (month, day, and year) Feb 2nd 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Thomas Doonan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Catherine Donoughe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Joseph V. Mc Kenna (Address) 327 Gwynn Avenue

15 MAR 19 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17

I HEREBY CERTIFY, That I attended deceased from August 15 1922 to March 16 1923.

that I last saw he alive on March 16 1923.

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis Laryngeal

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of About 1 yr ago

Was there an autopsy? No

What test confirmed diagnosis? Operative Findings.

(Signed) Mary A. McKenna M. D.

3/16, 1923 (Address) 1315 Eutaw Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3-19-1923

20 UNDERTAKER H. C. Brunning Son

ADDRESS Schroeder's

DEGREE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73907

REGISTERED NO. 12 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2840 Huntingdon Ave ST.: 17 WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob G. Butcher

(a) RESIDENCE. No. 2840 Huntingdon Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Butcher

6 DATE OF BIRTH (month, day, and year) 11-29-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

073

9 BIRTHPLACE (city or town) Pa.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Butcher

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Gamble

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Carroll Butcher
(Address) 2840 Huntingdon Ave

15 Filed MAR 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28 1923, to Mar 16 1923, that I last saw him alive on Mar 16th 1923, and that death occurred, on the date stated above, at 9.55 P m.

The CAUSE OF DEATH* was as follows:

Chronic ~~Acute~~ Nephritis Interstitial

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma and Intoxication (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emmy G. Brown, M. D.

, 19 (Address) 2409 Nod. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shrewsbury Pa.	Mar 19 19?
20 UNDERTAKER	ADDRESS
E. LEROY STIFFLER	125 E. North Ave

TION is very important. See instructions on back of certificates.
that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73908

CERTIFICATE OF DEATH.

74-001
D73908

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 7600 E. Hoffman St. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank G. Grau.

(a) RESIDENCE NO. 7600 E. Hoffman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Grau

6 DATE OF BIRTH (month, day, and year) Nov. 15-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Grau

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ger.

14 Interment
(Address) Catherine Hoffbeck Haught
760 E Hoffman St

15 Filed MAR 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1923, to Mar. 16, 1923,

that I last saw him alive on Mar. 15, 1923,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Lochbeckler, M. D.

, 19 (Address) 806 S. 32d St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	March 20 1923
20 UNDERTAKER	ADDRESS
Lilly & Zinler.	403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 O'Donnell St ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Emberley

(a) RESIDENCE NO. 3407 O'Donnell St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 19 - 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	26	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Emberly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Canada.

12 MAIDEN NAME OF MOTHER Mary E. Pabst.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mary E. Emberly.
(Address) 3407 O'Donnell St

15 Filed . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1923.

17 I HEREBY CERTIFY, That I attended deceased from June . 1919 . to Mar 15 . 1923.
that I last saw her alive on Mar 13 . 1923
and that death occurred, on the date stated above, at 6.55 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Tuberc. Peritonitis

about (duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? don't know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? autopsy X-Ray

(Signed) Martin F. Sloan M. D.

3/6, 1923 (Address) 4. 4 Prof. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	March 19 1923.
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

MAR 19 1923

CAUSES OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73910

CERTIFICATE OF DEATH.

101-001

D73910

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp'l ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Andrew Norton

(a) RESIDENCE. NO. 3011 Alameda Blvd. ST. ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married —

6 DATE OF BIRTH (month, day, and year) Mar 10th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mary E. Norton (Address) 3011 Alameda Boulevard.

15 Filed MAR 19 1923 19 ... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 17, 1923

that I last saw him alive on March 17, 1923

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kroger, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 20 1923
20 UNDERTAKER Robt J Turner Son	ADDRESS 1442 W Broadway

Spec.—1-10-21—M&T—1500 Blks.

D73911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73911

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1243 N Broadway ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Meyer

(a) RESIDENCE No. 1243 N Broadway ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write this word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Meyer

6 DATE OF BIRTH (month, day, and year) Apl 2 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Wm East

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant August Meyer

(Address) 1243 N Broadway

15 Filed MAR 19 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1922, to March 16, 1923, that I last saw her alive on March 16, 1923, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Several Years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sclerosis of Coronary Arteries

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. C. Sandrock, M. D.

17 3, 1923 (Address) 1242 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 19 1923
20 UNDERTAKER Clark Johnson	ADDRESS 1242 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73912 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D73912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 8 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. John Neveker

(a) Residence No. 1720 E Oliver St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Neveker

6-DATE OF BIRTH (month, day and year) July 31 1856

7-AGE. 66 yrs. 8 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Gas Meter
(b) General nature of industry, business, or establishment in which employed (or employer). Maker
(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country). Md

PARENTS.

10-NAME OF FATHER. ?

11-BIRTHPLACE OF FATHER (city or town). ?
(State or Country). ?

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town). ?
(State or Country). ?

14- (Informant) Mary Neveker
(Address) 1720 E. Oliver

15- Filed MAR 19 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 16 23

17- I HEREBY CERTIFY, That I attended deceased from Mar 6 19 23 to Mar 16 19 23

that I last saw him alive on Mar 16 19 23

and that death occurred, on the date stated above, at 11 40 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 1 yrs. 10 mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Symp. & Signs

(Signed) [illegible] M. D.

, 19 (Address) Private Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Rock Spring Cem	Mar 20 1923
20-UNDERTAKER,	ADDRESS
Robt J Turner Jr	W. Fayette

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73913

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2111 E Eager St., WARD)

2-FULL NAME Josephine V Bauserd

(a) RESIDENCE NO. 2111 E Eager St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M Bauserd

6 DATE OF BIRTH (month, day, and year) apr- 1850

7 AGE Years 1 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Valk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John M Bauserd (Address) 2111 E Eager St

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923 to March 16 1923

that I last saw h alive on March 16, 1923

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Indefinite

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Fred Leuch M. D.

(Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Mar 21 1923

20 UNDERTAKER Robt J Turner

ADDRESS N. Bway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73914

CERTIFICATE OF DEATH.

90 D73914

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6188 Bond ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rupinski

(a) RESIDENCE NO. 6188 Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Rupinski

6 DATE OF BIRTH (month, day, and year) April 10 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) poland

14 Informant Josephine Rupinski

(Address) 6181 Bond St

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1923 to March 16, 1923

that I last saw h[illegible] alive on March 16, 1923

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Moore, M. D.

(Address) 801 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL March 20 1923

20 UNDERTAKER John M Weber — ADDRESS 1903 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 101-002

D73915

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 501 N. Central Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Williams

(Residence in Baltimore: No. 501 N. Central Ave. St., (yrs. 15) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	black ~~White~~	married

6-DATE OF BIRTH. unknown (Month) (Day) 18 00 (Year)

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: house work
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). " "

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Williams

(Address) 501 N. Central Ave.

15- FILED MAR 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 15/23 (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural causes.
Pnuemonia(Primary)
(Indications when embalming)
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J S Coates M. D.
(Coroner.)

3/17/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cem.	Mch 19 1923
20-UNDERTAKER,	ADDRESS
Evans & S. Locks	1302 Jefferson

is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1274-001

D73916

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2324 N. Calvert St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Aline A. Story .....

(a) Residence No. 2324 N. Calvert St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick H. Story

6-DATE OF BIRTH (month, day and year) Dec 6 1868

7-AGE, 54 yrs. 2 mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town), (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Richard Keys

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, Mary Baker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Washington D. C.

14- (Informant) Miss Josephine V. Keys

(Address) 2324 N. Calvert St

15- FILED MAR 19 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

Calvin Gabriel 2413 St Paul St

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17/23

17- I HEREBY CERTIFY, That I attended deceased from Mch 6th, 1923, to Mch 17th, 1923, that I last saw him alive on Mch 17, 1923, and that death occurred, on the date stated above, at 2.15 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia right side

Complete

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) C. A. Gabriel, M. D.

, 19 (Address) 2413 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cem't | DATE OF BURIAL, March 22, 1923

20-UNDERTAKER, William Koch | ADDRESS 502 E Nat'l Ave

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Apoplectic

Pneumonia

2479

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73917

CERTIFICATE OF DEATH.

X 101-001

D73917

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Providence Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Perry

(a) RESIDENCE No. 717 S. St. Harrows Point Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John Harris Mt Winans

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 13th, 1923, to Mar 16th, 1923, that I last saw him alive on Mar 16th, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar-Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harrows Point Md

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical

(Signed) Fred. L. Brown, M. D.

3.17.1923 (Address) 1703 Freemason St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Mch 20 1923

20 UNDERTAKER John H Toadvine — ADDRESS 142 W Lieb St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73918

CERTIFICATE OF DEATH.

44

D73918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Brehms Lane near Belair Road ST., WARD)

2-FULL NAME William Rever REVER

(a) RESIDENCE No. Brehms Lane near Belair Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Rever

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Ackerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Julia Rever (Address) Brehms Lane Balto. Md.

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 18th, 1923, to March 18th, 1923, that I last saw him alive on March 18th, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

about (duration) 2 m. yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Operation Biopsy Path Report

(Signed) [illegible] M. D.

(Address) 2017 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Mch 21 1923
UNDERTAKER	ADDRESS
Fredk Lessenhop & Sons	Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Meise

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73919

D73919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Meise

(a) RESIDENCE. No. Park View Ave - Greenmeadow Road

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Meise

6 DATE OF BIRTH (month, day, and year) April 19 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Andrew Meise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER Barbara Sifkele

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Maryland

11 Informant Lawsale B. Meise

(Address) Southern Ave. Gardenville

15 Filed MAR 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 18, 1923, that I last saw h[illegible] alive on March 17, 1923, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. — mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 12-23

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) S W Kinney, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	March 20 1923
20 UNDERTAKER Fred Lasseter & Sons	ADDRESS Fullerton

CAUSE OF DEATH is to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73920

REGISTERED NO. 74-001 D73920

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Newington ave ST., 23 WARD)

2-FULL NAME Annie L. Muller

(a) RESIDENCE NO. 805 Newington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James N. Muller Jr

6 DATE OF BIRTH (month, day, and year) Aug 14 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adam Engelhaupt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Emma Engelhaupt 805 Newington Ave

15 FILED MAR 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 16, 1923, that I last saw h... alive on March 16, 1923, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. about mos 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

(Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Mar 19 1923

20 UNDERTAKER Geo. P. Evans & Son — ADDRESS 1180 W. Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec—12-23-21—E.B.R.S.—400 Blks.

D73921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73921

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Peter Crowford

(a) Residence No. 707 Hanover St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1872

7-AGE.	If LESS than 1 day.
50 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, James Crowford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER, Reda Mackina

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), South Carolina

14 (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 19 1923 192

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 16, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 12 19 23 to March 16 19 23

that I last saw him alive on March 15 19 23

and that death occurred, on the date stated above, at 5:30 A.M

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. 3-4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. Mucko M. D.

3-16-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Mch 19, 1923

20-UNDERTAKER.	ADDRESS
H. G. Brown's Son	1018 W Monto St

Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D73922

D73922

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 White ST.: 70 WARD)

2-FULL NAME Gilbert Nathaniel Russell

(a) RESIDENCE. NO. 1817 White ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8-1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William H. Russell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Rebecca Tasco

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Amelia Martin
(Address) 1817 White St.

15 Filed MAR 19 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1923

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to March 18, 1923, that I last saw him alive on March 17, 1923; and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) Chester Piland, M. D.

3-17, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 19 1923
20 UNDERTAKER	ADDRESS
Wm. H. Tasco Son	1400 Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73923

CERTIFICATE OF DEATH.

31

D73923

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 855 Hamilton Terrace ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth. Dail Greble

(Residence in Baltimore: No. 855 Hamilton Terrace St.; 19 yrs., 11 mos. 2 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 15th, 1903 (Month) (Day) (Year)

7-AGE, 19 yrs. 11 mos. 2 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, William H. Greble

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER Mary Olivia Dail.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Greble

(Address) 855 Hamilton Terrace

15- MAR 19 1923 ROBERT R. KRAUTER,
Filed ....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 17, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 6th 1922, to March 17th 1923, that I saw her alive on March 17th 1923, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robt. L. L. Lumpkin M. D.

March 17th, 1923 (Address) 11 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Mch 20, 1923

20-UNDERTAKER Chas. E. Franck ADDRESS 807 Madison Ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73924

CERTIFICATE OF DEATH.

100-001 D73924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2331 E. Madison ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis L. Lacher

(a) RESIDENCE NO. 2331 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6-22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Albert V. Lacher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary E. Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Albert V. Lacher

(Address) 2331 E. Madison

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 11, 1923, to Mar. 17, 1923,

that I last saw her alive on Mar. 17, 1923,

and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj. D. Hamburger M. D.

3/18 1923 (Address) 126 N. Curtins at

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk — DATE OF BURIAL 3/20 1923

20 UNDERTAKER: Philip Henrig — ADDRESS 2016 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

D73925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D73925

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1255 Battery Ave. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Creighton

(a) RESIDENCE NO. 1255 Battery Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A.Creighton

6 DATE OF BIRTH (month, day, and year) Jan.19 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of Industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co.Md.

PARENTS

10 NAME OF FATHER George W.Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret A.Gootee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Annette V.Creighton

(Address) 1255 Battery Ave.

15 MAR 19 1923 Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar.16 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15, 1923, to Mar. 16, 1923, that I last saw her alive on Mar. 16, 1923, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Dilated Heart

(duration) 1 yrs. mos. ds.

Bronchial Pneumonia

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) A. Hurst Chaplin, M. D.

(Address) 1340 E. Chase, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Mar 19 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Eighth St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73926

CERTIFICATE OF DEATH.

D73926

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4100 Hate ave St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Howell

(a) Residence No. 4100 Hate ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 21, 1860

7-AGE, 62 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER William Long

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Susanna Duncan

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Maryland

11- (Informant) W. E. Howell

(Address) 4100 Hate Ave

ROBERT N. KRAUTER

15- MAR 19 1923 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 16, 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 8 1914 to March 16 1923 that I last saw h.... alive on March 16 - 23, and that death occurred, on the date stated above, at 9 30 P m. The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none required

(Signed) John J. Kring M. D

March 19 23 (Address) 1423 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Parkleau — DATE OF BURIAL. Mar 19 1923

20-UNDERTAKER. George J. Smith — ADDRESS 1532 Hollins

instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73927

CERTIFICATE OF DEATH.

D73927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hilldale Balto. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G. Bailey

(a) RESIDENCE NO. Hillsdale Balto. 28 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Virginia M. Bailey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Dorchester Co.
(State or country)

PARENTS

10 NAME OF FATHER John Bailey

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Virginia M. Bailey
(Address) Hillsdale, Md.

Filed MAR 19 1923 19.... Burial Permit Clerk.

Registrar

ROBERT R. KRAUTER.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/17 .1923., to 3/17 .1923.
that I last saw him alive on 3/17 .1923
and that death occurred, on the date stated above, at 7.30P m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) 3 hours mos. ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. G. Everhart M. D.

3/18. 1923 (Address) Woodlawn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Mar 20 1923
20 UNDERTAKER	ADDRESS
Geo J Smith	532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73928

106-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Bayard ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris G. Sievert

(a) RESIDENCE. No. 1125 Bayard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Frank H Sievert
(Address) 1125 Bayard

15 Filed MAR 19 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 9, 1923, to Mch 18, 1923, that I last saw h alive on Mch 18, 1923, and that death occurred, on the date stated above, at 4, P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Harwood Hall, M. D.

, 19 (Address) 927 N Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 24 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73929

CERTIFICATE OF DEATH.

2 D73929

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Seed

(a) RESIDENCE NO. 227 Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown - Deceased wife

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER -

11 BIRTHPLACE OF FATHER (city or town) (State or country) -

12 MAIDEN NAME OF MOTHER -

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant U. S. Records (Address) 227 Fulton Ave

15 Filed MAR 19 1923 19 ....

INQUEST

Burial Permit Clerk.

Registrar

KRAUTER.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~3/10~~ 3/12, 1923, to 3/17, 1923, that I last saw him alive on 3/17, 1923, and that death occurred, on the date stated above, at 11:15 a. m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

Chronic

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of 3/12/23

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) C. M. Stapley, M. D.

3/19, 1923 (Address) 15 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Mar 20 1923

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins St

Spec. 1-10 21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73930

CERTIFICATE OF DEATH.

100-001 D73930

1-PLACE OF DEATH University Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No) ..... ST., 22 WARD)

2-FULL NAME Lavinie Byler

(a) RESIDENCE NO. 653 Washington ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	80			

8 OCCUPATION OF DEAD

(a) Trade, profession or particular kind of work Housework.

(b) General nature of Industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Wm. Byler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Sarah La Rue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant University Hospital Records (Address)

15 Filed MAR 19 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/11, 1923, to 3/18, 1923, that I last saw her alive on 3/18, 1923, and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. ... mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) W Hollister, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park [illegible]

DATE OF BURIAL: Mar 22 1923

20 UNDERTAKER: George J Smith

ADDRESS 1532 Hollins

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73931 — CERTIFICATE OF DEATH. — 161-01 — D73931

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 S. Pulaski St. 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Naoma Stamer

(a) RESIDENCE. No. 35 S. Pulaski St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 2/26/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			21	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry B. Stamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Helen Lehrer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Helen Stamer (Address) 35 So Pulaski St

15 Filed MAR 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/26, 1923, to 3/18, 1923, that I last saw her alive on 3/18, 1923, and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows:

Cessation 8 months.
Mother of this child has a
severe Chronic Nephritis

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Heller Henning M. D.

3/19, 1923 (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mar 20 1923
20 UNDERTAKER	ADDRESS
George J Smith	Hollins 1532

TION is very important. See instructions on back of certificates.

D73932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80

D73932

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 331-E 21½ St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl Bland

(Residence in Baltimore: No. 331 E. 21½ St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colard	Infant

6-DATE OF BIRTH. Nov 7 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Luther Bland

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Rebecca Fields

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Fields

(Address) 331 21½ st

15-

FILED MAR 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 16 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Convulsions

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner.)

March 17 1923 (Address) 36 E. 21½ St Baltimore

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loud County	March 19 1923
20-UNDERTAKER. John H Owens	ADDRESS 538 Dolphin st

Make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73933

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward) 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Professor Howell

(a) Residence No. 832 Plover St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1859

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Jacob Howell

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Daisy Smith

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Virginia

11- (Informant) Municipal Hospital Records

(Address).....

13- MAR 19 1923 ROBERT A. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 15, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 12, 1923, to March 15, 1923, that I last saw him alive on March 15, 1923, and that death occurred, on the date stated above, at 2:10 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

3-16 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, 3-19 1923

20-UNDERTAKER, Samuel Kennedy ADDRESS 738 Bdle

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

Stromberg

D73934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D73934

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 Rosedale St. 20 WARD)

2-FULL NAME Helen Rosalie Stromberg

(a) RESIDENCE No. 436 Rosedale St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 [illegible]

7 AGE — Years | Months | Days | If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Maxim Stromberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Esther Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: G. Stromberg
(Address): 436 Rosedale

15 MAR 19 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 18, 1923

that I last saw her alive on March 18, 1923,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Asthenia

(duration) ... yrs. ... mos. 11 hrs. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edward W. Jones, M. D.

3/19/23 (Address) 222 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral — DATE OF BURIAL: March 19 1923

20 UNDERTAKER: Wm. M. & S. Finn — ADDRESS: 1727 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lbks.

Baker

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D73935

D73935

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Balto 1630 Brune ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta Baker

(a) RESIDENCE. No. 1630 Brune ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE — Years: 52 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress.

(b) General nature of industry, business, or establishment in which employed (or employer): 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Montgomery Co Md

PARENTS

10 NAME OF FATHER: Henry Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Edward Kennard
(Address) 1630 N. Bruce St

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-14-, 1923, to 3-16-, 1923, that I last saw h.. alive on 3-16-, 1923, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows: Mitral Insufficiency

3 wks
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastritis
19x (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Barton, M. D.

, 19 (Address) 1618 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MK Cabin — DATE OF BURIAL: Mar 19 1923

20 UNDERTAKER: James R. Lewis — ADDRESS 313 E Fayette

TION is very important. See instructions on back of certificates.

...ng of property classified as Real Estate Statement of OCCUPA-

Mad 631-9.

Spec.—1-10-21—M&T—1500 Bks.

D73936 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D73936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 N. Gilmor ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Fizer

(a) RESIDENCE NO. 1229 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11, 22.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	—	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER Wm Fizer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Tenn

12 MAIDEN NAME OF MOTHER Gertrude Blakiston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Emma Blakiston

(Address) 1229 N. Gilmor St.

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 16th 1923, to Mar 18th 1923, that I last saw her alive on Mar 17th 1923, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. not known mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical.

(Signed) Harvey G. Brown, M. D.

3/18/1923 (Address) 156 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Gilmor — DATE OF BURIAL: Mar. 19. 1923

20 UNDERTAKER: Fuller & Dennis. — ADDRESS 203 Goodman

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Barbara Goodrich) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73937

CERTIFICATE OF DEATH.

31 D73937

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 336 Agnes ave ST. 20 WARD)

2-FULL NAME Barbara J Goodrich

(a) RESIDENCE. No. 336 Agnes ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse W. Goodrich

6 DATE OF BIRTH (month, day, and year) Aug 1-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Kates Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara E. Shoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Jesse W. Goodrich (Address) 336 Augusta Ave

15 Filed MAR 19 1923 19.. ROBERT M. KRAUTER. Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 8, 1923, to March 17, 1923, that I last saw h[e]r alive on March 17, 1923, and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C Gebert, M. D.

3/19, 1923 (Address) 2151 Shelburne

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 20 1923

20 UNDERTAKER George L. Schnat ADDRESS 2101 Eutaw ave

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

✓ Scott St.

D73938

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D73938

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1226 Cleveland. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna. Volkmann.

(a) Residence No. 1226 Cleveland. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Leopold. Volkmann.

6-DATE OF BIRTH (month, day and year) April 25 1853

7-AGE. 69 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14-INFORMANT. Adolph. Volkmann.

(Address) 1226 Cleveland. St

15-FILED MAR 19 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-17-23

17. I HEREBY CERTIFY, That I attended deceased from March 15 1923 to March 17 1923 that I last saw h.. alive on March 16 1923 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

3/18, 1923 (Signed) Edw. Emerson Jr. M. D.

(Address) 517 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, 1923
20-UNDERTAKER. E. E. Harden	ADDRESS 110 E. West St.

Instructions on back of certificates.

Stamp. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73939

CERTIFICATE OF DEATH.

74-001

D73939

REGISTERED NO.....

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. 2923 St. Paul ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Murphy

(a) RESIDENCE NO. 2923 St. Paul st ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime 80 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis P. Murphy

6 DATE OF BIRTH (month, day, and year): Unknown 1837

7 AGE: Years 86 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Scanlon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Jones

(Address): 2923 St Paul St.

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 17-1923

17 I HEREBY CERTIFY, That I attended deceased from March 3 1923 to March 17 1923, that I last saw h alive on March 16 1923, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Due to Cerebral Hemorrhage)

(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferies Burns M.D.

3/18 1923 (Address) 2926 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: March 20th 23

UNDERTAKER: Chas S. Evans & Son — ADDRESS: 1108 W. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

161670
D73940

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. " ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Earle.

(a) RESIDENCE No. 636 Hampton Ave; Greenville, S.C.
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Earle wife.

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1891.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant Ofc
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS
10 NAME OF FATHER S. W. Earle.
11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.
12 MAIDEN NAME OF MOTHER Martha Hill
13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Friends

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to March 18, 1923, that I last saw him alive on March 15, 1923, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Mediastinal Tumor

about 2 months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) weakness and anemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Greenville S.C.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X Rays on two occasions

(Signed) Chas. H. Berg, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sumter S.C. DATE OF BURIAL 3/19 1923

20 UNDERTAKER [illegible] ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73941

CERTIFICATE OF DEATH.

D73941

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Weldon Ave. St.; 43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nannie A. Collins

(Residence in Baltimore: No. 1303 Weldon Ave St.; 2 yrs. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Nov. (Month) 17 (Day), 1879 (Year)

7-AGE, 43 yrs. 4 mos. — da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Dates

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, James H. Collins

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary E. Watkins

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Collins

(Address) Galberton, Md.

15- MAR 19 1923 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 17 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1921, to March 17 1923, that I saw h[illegible] alive on March 16 1923, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma

from the uterus

[illegible]

(Duration) 1 yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 1 da.

(Signed) [illegible] M. D.

March 17, 1923 (Address) 342 Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence Galberton, Md.

19-PLACE OF BURIAL OR REMOVAL. Good Shepherd Cem. DATE OF BURIAL. March 19, 1923

20-UNDERTAKER Easton Sons ADDRESS Ellicott City

important. See instructions on back of certificate. Every statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

D73942

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D73942

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor STREET, 10 WARD)

2-FULL NAME Catherine Megowan

(a) RESIDENCE NO. Fraser Valley Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) April 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	64	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) New Brunswick (State or country) Canada.

PARENTS

10 NAME OF FATHER Wm. Megowan

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER Margaret Meglois

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Little Sisters of the Poor. (Address) Fraser & Fayette

15 MAR 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 1 1923 to ..... 19.....

that I last saw her alive on March 11 1923

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis

Paralysis (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F.A. Warner, M. D.

March 18, 1923 (Address) 1133 Valley Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	Mar 20 1923
20 UNDERTAKER	ADDRESS
H.C. Wiedefeld	914 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73943

CERTIFICATE OF DEATH.

101-001 D73943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6012 York Road ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Kemp Jr

(a) RESIDENCE. No. 6012 York Road ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dahlgren Kemp

6 DATE OF BIRTH (month, day, and year) 6 or 11

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sec & Treas of Balto Base Ball Club.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey.

PARENTS

10 NAME OF FATHER John Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant John Kemp

(Address) 6012 York Road

13 19 1923 19 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 12, 1923, to Mar. 18, 1923,

that I last saw h— alive on Mar. 18 —, 1923,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (R)

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Hoen, M. D.

3-19 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Govans	March 20 1923
20 UNDERTAKER E. A. Redfield Jr	ADDRESS 501 E 32 St.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73944

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D73944

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1526 Baker Street 15 WARD)

2-FULL NAME Isaac Schaffer

(a) RESIDENCE No. 1526 Baker Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Schaeffer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant 1453

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warsaw Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warsaw Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Warsaw Poland

14 Informant Jack Laws

(Address) 1439 Eutaw St

15 Robert P. Harrison, Burial Permit Clerk. Registrar

19 1923 2nd .19.....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18 1923

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1923, to March 18, 1923,

that I last saw him alive on March 18, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Uremic coma

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) chronic diffuse nephritis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine, Blood Pressure

(Signed) Jack Levin, M. D.

4/9 1923 (Address) 223 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fifteen Friendship

DATE OF BURIAL March 20 19 23

20 UNDERTAKER Jack Laws, 1439 E. Baltimore

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73945

D73945

CERTIFICATE OF DEATH.

REGISTERED NO. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hosp ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McCullough

(a) RESIDENCE NO. Linebora Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 17. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of indnstry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Geo McCullough.

11 BIRTHPLACE OF FATHER (city or town) Penna
(State or country)

12 MAIDEN NAME OF MOTHER Laura Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant
(Address) OHNS HOPKINS HOSPITAL

Filed MAR 19 1923, 19 Robert P. Harrison, M.D. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1923. to Mar 17, 1923.

that I last saw h alive on Mar 17, 1923

and that death occurred, on the date stated above, at 1:45 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

Lived 15 minutes

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) R D Harmon M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL OHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Undertaker reports:

Dpy. Wm. S. WOODALL

ADDRESS MAR 19 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73946 HEALTH DEPARTMENT—CITY OF BALTIMORE D73946

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Williams

(a) RESIDENCE No. 1023 Pennsylvania ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Williams

6 DATE OF BIRTH (month, day, and year) 1893 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

8b

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14 Informant Hospital Records
(Address) M.G.H. UNIVERSITY OF MARYLAND.

15 Filed ..... 19 ..... Registrar

19 1923

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 19 23

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1923, to March 14, 1923, that I last saw her alive on March 14, 1923, and that death occurred, on the date stated above, at 6.40 p. m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) yrs. 6 ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum

(Signed) T. Bedaglinecca, M. D.

5-15-23 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

MAR 1923

Spec.—1-10-21 M&T 1500 Blks.

D73947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73947

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Benjamin

(a) RESIDENCE No. 643 Josephine st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

040

9 BIRTHPLACE (city or town) (State or country) Haiti

PARENTS

10 NAME OF FATHER Phelion Benjamin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Haiti

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Hospital Records

(Address) U.T.H.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to March 14, 1923, that I last saw him alive on March 14, 1923, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis D. Delegracia M. D.

3-14-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
UNIVERSITY OF MARYLAND.	
20 UNDERTAKER Commissioner Health	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 19 1923

Robert E. Lee Bldg. Burial Permit Clerk.

MAR 19 1923

Spec.--1-10-21--M&T--1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73948 ✓

D73948

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella Jackson

(a) RESIDENCE No. 820 Ashland ave. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address) M.C.H.

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1923, to March 14, 1923, that I last saw her alive on March 14, 1923, and that death occurred, on the date stated above, at 1.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Florence L. Sadaglioccs, M. D.

3-14-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	19
20 UNDERTAKER Commissioner Health.	ADDRESS

MAR 19 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73949

CERTIFICATE OF DEATH.

63

D73949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2416 East Oliver ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie J. Johnston

(a) RESIDENCE NO. 2416 East Oliver ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua H Johnston

6 DATE OF BIRTH (month, day, and year) June 14-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 637

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Albert F. Loetz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joshua H Johnston

(Address) 2416 E Oliver

15 1923 ..... 19 .....

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1923

17 I HEREBY CERTIFY, That I attended deceased from January 2nd, 1923, to March 17, 1923, that I last saw her alive on March 16, 1923, and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Addisons Disease

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 3- mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) G E Burton, M. D.

3/18. 1923 (Address) 301 E Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem.

DATE OF BURIAL March 20 1923

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1411 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73950 ✓ 101-09 D73950

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mrs. Cecelia Miller

(a) Residence No. 203 Fremont St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Miller

6-DATE OF BIRTH (month, day and year) 1882.

7-AGE. 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS

10-NAME OF FATHER, Edward Farrell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Hart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Hospital Information

(Address) Calvert & Saratoga Sts

15- Filed 19 1923 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov 16 '23

I HEREBY CERTIFY, That I attended deceased from Oct 28 19 23 to Nov 16 19 23

that I last saw h. alive on Nov 16, 19 23

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Empyema

(Duration) 2 yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Failure.

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. Freeman, M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem

DATE OF BURIAL. 11/20, 1923

20-UNDERTAKER. Margaret L. Flynn

ADDRESS 411 Light St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D73951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D73951

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1337 Richardson St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Burl

(a) Residence No. 1337 Richardson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 11-1922

7-AGE.	If LESS than 1 day,
....yrs. 3 mos. 7 ds.	....hrs. or. ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant.

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Burl.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Nora Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) John Burl

(Address) 1337 Richardson

15- Filed 9 1923, 192. Robert P. Harrison, Registrar.

Burial Permit Given?

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 18 1923

17- I HEREBY CERTIFY, That I attended deceased from March 17, 1923 to March 18 1923

that I last saw h alive on March 17, 1923

and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(uncomplicated)

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. Speoms, M. D.

3/8, 1923 (Address) 2878 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	Mar 20, 1923
20-UNDERTAKER. Margaret G. Flynn	ADDRESS 1 N Eutaw St.

Please fill in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

162018
D73952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. " " " ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Cerute.

(a) RESIDENCE NO. 1603 Pendleton St. ST., Columbia, S.C. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. — mos. 14 ds. How long in U. S., if of foreign birth? — yrs. — mos. 15 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Evelyn (Daughter.

6 DATE OF BIRTH (month, day, and year): Sept. 2, 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship-builder.

(b) General nature of Industry, business, or establishment in which employed (or employer): (-) 086

(c) Name of employer: (-)

9 BIRTHPLACE (city or town) (State or country): W. D.

PARENTS

10 NAME OF FATHER: Theodore Cerute.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mathilda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. D.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Geneva —

Filed 19 1923 . 19

Robert F. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923 (to) March 19, 1923.

that I last saw him alive on March 19, 1923.

and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Pulmonary embolism

(duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? Columbia S.C.

Did an operation precede death? Yes Date of Mar. 16th 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Franklin F. Thomson, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbia S.C.

DATE OF BURIAL: 3/19 19 23

20 UNDERTAKER: H. E. Hughes

ADDRESS: 1st & Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D73953 HEALTH DEPARTMENT—CITY OF BALTIMORE D73953

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH 619 Seneca St. Registered No.....

City of BALTIMORE: (No.....St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mame Sapp

(a) Residence No. 619 Seneca St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 8, 1902

7-AGE, 21 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Hay Fever

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ballo, Md

PARENTS.

10-NAME OF FATHER, John Sapp

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ballo, Md

12-MAIDEN NAME OF MOTHER, Jenny Clark

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md

14- (Informant) Jenny Chumbley

(Address) 619 Seneca St

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17-1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 20 23 to March 17 23, that I last saw h alive on March 17 1923 and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Kidney Disease

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Unknown

(Signed) J. W. Hartzell M. D.

, 19 (Address) 3 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cathedral	Mar. 13, 1923
20-UNDERTAKER, Wm Cook	ADDRESS 502 E Monument

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73954

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 677 E. Barre ST.: 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Constantine

(a) RESIDENCE. No. 677 E. Barre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Lucretta Constantine

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John H. Constantine

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Lemstrin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. L. Constantine
(Address) 677 E. Barre St.

15 Filed Robert P. Harrison, Registrar
19 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1922, to Mar 18, 1923, that I last saw him alive on Mar 18 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism unable to state

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. F. Phillips, M. D.

Mar 19, 1923 (Address) 1929 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westernview	March 22 1923

20 UNDERTAKER	ADDRESS
Robert S. Little	3700 Edmondson Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73955 / 31 D73955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2023 Ridgewood Ave Ward) 15

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie P. Triplett

(a) Residence No. 2023 Ridgewood Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed or divorced HUSBAND of (or WIFE) Charles E Triplett

6-DATE OF BIRTH (month, day and year) Nov 29 1899

7-AGE. 23 yrs. 3 mos. 18 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER John Fisher

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary Fisher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Charles Triplett

(Address) 2023 Ridgewood Ave

15- Filed MAR 20 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1922 to March 17 1923

that I last saw h alive on March 17 19.....

and that death occurred, on the date stated above, at 2.15 P m

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

About

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

About 6

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? physical

(Signed) Walter S Triplett M. D.

March 19 1923 (Address) 2220 Harford

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL, March 20 23

20-UNDERTAKER. Cohenower & Son — ADDRESS Chestnut Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D73956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73956

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 716 W 34th St St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurence E Stewart

(a) Residence No. 716 W 34th St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 24 1921

7-AGE, 1 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Gds

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John W. Stewart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Nellie Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-Informant John W Stewart

(Address) 716 W 34th St

15-FILED MAR 20 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 18/23

17- I HEREBY CERTIFY, That I attended deceased from March 3 1923 to March 18 1923, that I last saw him alive on March 18 1923, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Wurtz M. D.

March 19 1923 (Address) 865 W. 36th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn

DATE OF BURIAL, March 20 1923

20-UNDERTAKER. Chenowith & Son

ADDRESS Chestnut Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D73957

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 E West St. 24 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Stalls

(a) RESIDENCE. No. 131 E West St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Stalls

6 DATE OF BIRTH (month, day, and year) Oct 1 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Geo Neibauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mod Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) J Henry Stalls. 131 E. West St

15 MAR 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16/23

17 I HEREBY CERTIFY, That I attended deceased from 12/22, 19 22, to 3/16, 19 23, that I last saw h alive on 3/16, 19 23, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chron. Interstitial nephritis (duration) unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mrs. Stifler, M. D.

3/17, 1923 (Address) 1319 Eight St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A & B	3-20 1923
20 UNDERTAKER	ADDRESS
Ed B Hale	115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73958

38 D73958

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 S Dulton ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Mercer

(a) RESIDENCE. No. 437 S Dulton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19 — 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Mercer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant E. Mercer

(Address) 437 S Dulton ave

15 FILED MAR 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1923

17 I HEREBY CERTIFY, That I attended deceased from February 8 1923 to March 19 1923 that I last saw him alive on March 19 1923 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Aguneus. Pneumonia
Endocarditis

(duration) Weeks Days

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Ritch M. D.

3/19 1923 (Address) 2151 Dulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 22 1923
20 UNDERTAKER MR. & MRS. N. S. PINK, FUNERAL DIRECTORS 1886 W. PRATT STREET.	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73959

CERTIFICATE OF DEATH.

90 D73959

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1431 Park Ave ST. 14 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Isabella K. Godfrey.

(Residence in Baltimore: No. 1431 Park Ave. 65 yrs., 4 mos. 11 ds.)

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Wid'g

6-DATE OF BIRTH, Nov. 8, 1857 (Month) (Day) (Year)

7-AGE, 65 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): 054

9-BIRTHPLACE, (State or Country), Ba Co. Md.

PARENTS.

10-NAME OF FATHER, Andreas Godfrey

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Isabella Kennedy

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. Davies

(Address) 1431 Park Ave.

15- MAR 20 1923 Filed ....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 19, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Physician's
Organic Heart disease
(Duration) 19 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. J. Hennessy M. D. (Coroner.)

March 19 1923 (Address) 2502 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL: Greenmount Cem — DATE OF BURIAL, 3-21-1923

20-UNDERTAKER: Henry W. Jenkins Sons Co — ADDRESS Orchard abv Collington

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73960

CERTIFICATE OF DEATH.

38

REGISTERED NO. D73960

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Argyle Ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos Blady

(a) RESIDENCE NO. 1126 Argyle Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Brady

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trader 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md

PARENTS

10 NAME OF FATHER Richard Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Brady

(Address) 1126 Argyle Ave

15 FILED MAR 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/ 1923

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1923, to March 17, 1923.

that I last saw him alive on March 17, 1923,

and that death occurred, on the date stated above, at 5-20 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. 2 mos ' ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. L. Wheatley, M. D.

3/19. 1923 (Address) 1232 E. Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar. 20 1923
20 UNDERTAKER Jas. H. Dennis	ADDRESS 303 Druid Hill Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73961

CERTIFICATE OF DEATH.

90 D73961

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1159 Wheatcroat ST., 16 WARD)

2-FULL NAME Lottie Wise

(a) RESIDENCE NO. 1159 Wheatcroat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Wise

6 DATE OF BIRTH (month, day, and year) Mar 14. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Isaac Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosella Hopkins

(Address) 1159 Wheatcroat St

15 MAR 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 11th 1923 to Mar 18 1923.

that I last saw her alive on Mar 16th 1923

and that death occurred, on the date stated above, at 1.30A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. not known mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. not known mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F Brown, M. D.

3/19 1923 (Address) 1501 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mar. 21 1923
20 UNDERTAKER James F. Lewis	ADDRESS 1305 Druid

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73962

CERTIFICATE OF DEATH.

4 × 170

D73962

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andres Ontaneda

(Residence in Baltimore: No. USA Hotel St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male.	White	Single

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 24 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Ft Sailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... U.S.

9-BIRTHPLACE, (State or Country). Porta Rica

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) U.S.V. Bureau

(Address) 22 Light st.

15-

MAR 20 1923. 19.. ROBERT F. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 17, 1919
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot by pistol shot wound in mouth

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration).....yrs.....mos.....ds.

(Signed) W. J. Riley M. D.
(Coroner.)

March 19, 1919 (Address) 105 E Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Arlington Virginia	3/20, 19..
20-UNDERTAKER S. Gunson & Bro	ADDRESS 1127 E Balto st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73963

CERTIFICATE OF DEATH.

D73963

Registered No. 47

1-PLACE OF DEATH

City of BALTIMORE: (No. 1710 W North ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lena Spielsdock

(a) Residence No. 1710 W North ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emanuel Spielsdock

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer). House Wife

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harman Goldsmith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Caroline Goldsmith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Samuel Schiron

(Address) 1710 W North ave

15- Filed MAR 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 19/23

17. I HEREBY CERTIFY, That I attended deceased from Mar. 15 1923 to Mar. 19 1923

that I last saw h[illegible] alive on Mar. 19 1923

and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Lung

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of 4 yrs ago

Was there an autopsy? No

What test confirmed diagnosis? Self evident

(Signed) R. C. Metz M. D

Mar 19 1923 (Address) 1903 W North ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Friendship DATE OF BURIAL. March 20 23

20-UNDERTAKER. J. Ahrens & Co ADDRESS 1611 Mad ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dron

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73964

CERTIFICATE OF DEATH.

90 D73964

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame Charles St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Apollonia Dron

(a) RESIDENCE NO. Charles St. Ave ST., 27, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 5 mos. ½ ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6th 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria, Germany

PARENTS

10 NAME OF FATHER Sebastian Dron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria Germany

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria Germany

14 Informant Sister M. Philemon

(Address) Charles St. Ave. Balto.

15 MAR 20 1923 ROBERT R. KRAUSER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1923, to Mar 18, 1923,

that I last saw her alive on Mar 18, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia *

Bronchial asthma

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Simms, M. D.

3/18, 1923 (Address) 4706 Liberty Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govenstown Cem. Private	March 21 1923
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73965 HEALTH DEPARTMENT—CITY OF BALTIMORE 374-001 D73965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 721 Ramsey St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Hill

(Residence in Baltimore: No. 721 Ramsey St., 44 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word): Married

6-DATE OF BIRTH: Feb (Month) 28 (Day) 1879 (Year)

7-AGE: 74 yrs. ..... mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country): Balt city

PARENTS.

10-NAME OF FATHER: John Hill

11-BIRTHPLACE OF FATHER, (State or Country): city

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country): " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James C Hill

(Address) 2604 McElderry St

15- Filed MAR 20 1923 192.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (~~Inquest, autopsy~~ or Inquiry.) thereon and from the evidence obtained by said..... (~~Inquest, autopsy or Inquiry.~~) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) a go

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H B Jameson M. D. (Coroner.)

3-20 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: London Park Cem — DATE OF BURIAL: March 1923

20-UNDERTAKER: Wm J Tuckman & Son — ADDRESS: North & Pa ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73966

CERTIFICATE OF DEATH.

101-001

D73966

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 946 Warner St. 22 WARD)

2-FULL NAME John Broom

(a) RESIDENCE. No. 946 Warner ST., 22 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Broom

6 DATE OF BIRTH (month, day, and year) Nov 9. 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Cleveland 140

(c) Name of employer Balto Bergan House

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Broom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lula Gantt

(Address) 611 Burgundy St.

15 Filed MAR 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/1923

17 I HEREBY CERTIFY, That I attended deceased from 3/9/23, to 3/17/23, that I last saw h... alive on ..., and that death occurred, on the date stated above, at 5.00a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

3/18/23 (Signed) J. Gunbowley M. D.

(Address) 908 S Shark St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Auburn Cemetery	Mar. 20 1923

20 UNDERTAKER	ADDRESS
Wm. S. A. Hooper	406 W. Cary

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73967 — 001 — 122 — D73967

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3512 Old York Road ST., 9 WARD)

2-FULL NAME Richard J. Mooney

(a) RESIDENCE NO. 3512 Old York Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Katherine E. Mooney

6 DATE OF BIRTH (month, day, and year) February 13 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of Industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Richard Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Katherine E. Mooney
(Address) 3512 Old York Road

15 Filed ....., 19 ROBERT R. KRAUTER, Registrar
MAR 20 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1923

17 I HEREBY CERTIFY, That I attended deceased from January 19th 1923 to March 19th 1923, that I last saw h— alive on March 19th 1923 and that death occurred, on the date stated above, at 4 40 P. m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of the Liver.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

3/20/23 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 22 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E. Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73968

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D73968

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2512 N. Fairmount Ave (ST.) (WARD) 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis A. Krein

(a) RESIDENCE No. 2512 N. Fairmount Ave ST. WARD

(Usual place of abode) (If non-residents give city or town and State)

Length of residence in city or town where death occurred 76 yrs. — mos. — ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Krein

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe maker

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Krein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr John F. Krein

(Address) 2512 N Fairmount Ave.

15 Filed MAR 20 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15 1923 to March 19 1923, that I last saw him alive on March 18 1923, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Senility

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James L. Hooper, M. D.

3-19-1923 (Address) 346 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL March 21 1923

20 UNDERTAKER Henry Storck Son — ADDRESS 1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D73969

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST., 5 WARD)

2-FULL NAME Mrs. Sarah Olsen

(a) RESIDENCE NO. 715 E. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samp Olsen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Passy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Baltimore

15 MAR 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19, 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 13, 1923, to Mar. 19, 1923.

that I last saw h.. alive on Mar. 19, 1923,

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (Chr. nephritis)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood chemistry

(Signed) Isidore S. Frey M.D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 3/20 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73970

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 107 N. Ann Street ST., 6 WARD)

2-FULL NAME Dora Rubin

(a) RESIDENCE NO. 107 N. Ann Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reuben Rubin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Rubin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie ... [illegible] March 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Annie Cohen

(Address) 107 N. Ann street

15 MAR 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1923

17

I HEREBY CERTIFY, That I attended deceased from February, 1923, to March 18, 1923, that I last saw h[illegible] alive on March 10, 1923, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Symptoms a few months)

? (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Coronary artery disease

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harold J. Krulla, M. D.

(Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 3/20 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73971

CERTIFICATE OF DEATH.

44 D73971

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 46 S Catherine ST., 20 WARD)

2-FULL NAME A Katherine Schrock

(a) RESIDENCE NO. 46 S. Catherine ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Schrock

6 DATE OF BIRTH (month, day, and year): Dec 5-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Adam Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Weiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Albert F. Schrock

(Address): 76 S Catherine St

15 FILED MAR. 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 17 1923

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to March 17, 1923.

that I last saw her alive on March 17, 1923

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinomata Stomach & Liver - Endocarditis

(duration) Unknown yrs.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) ..... yrs. ..... mos. 2 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Norbert C. Hytche M.D.

3/18, 1923 (Address) 2151 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: March 1923

20 UNDERTAKER: John Ellicott

ADDRESS: 2005 Orleans

BEFORE SIGNING BE CAREFULLY SUPPLIED. ALL should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1673469
D73972,

HEALTH DEPARTMENT—CITY OF BALTIMORE

21 D73972

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " St. 7 WARD)

JOHNS HOPKINS HOSPITAL

2-FULL NAME Marie Davis.

(a) RESIDENCE NO. 815 Mc Donough St City WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Mary Davis, (mother).

6 DATE OF BIRTH (month, day, and year) Aug 16, 1922.

7 AGE: Years 1 Months 7 Days 1 — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Charles Davis.

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary ?.

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) U. S.

14 Informant (Address) Friends

15 Filed MAR 20 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 18, 1923, that I last saw her alive on March 18, 1923, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Erysipelas + Streptococcus Septicaemia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy + Blood Culture

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: March 20 1923

20 UNDERTAKER: Mrs Robert F Elliott — ADDRESS: 1725 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

162 047. D73973

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 D73973

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 5

CITY OF BALTIMORE: (No. ... ST., 3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Washington

(a) RESIDENCE NO. 431 Aisquith St. City ST. ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~or) WIFE of~~ Charles Washington (father)

6 DATE OF BIRTH (month, day, and year) Dec 24, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	21.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child. 00
(b) General nature of Industry, business, or establishment in which employed (or employer) "
(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Washington

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) Va

12 MAIDEN NAME OF MOTHER Unc[illegible]

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Bears Records

15 Filed MAR 20 1923 ROBERT R. KRAUTER, Registrar
Buried Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 17, 1923, that I last saw h[illegible] alive on March 17, 1923, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:
Tuberculous Meningitis.

(duration) — yrs. — mos 15 ds.

CONTRIBUTORY (Secondary) Pulmonary + Miliary 26 d

(duration) yrs. 8 mos. 17 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Tuberculin Pirquet

(Signed) Horton Casparis M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredricksburg Va.

DATE OF BURIAL Mch. 20 1923

20 UNDERTAKER Mrs J. E. Locke

ADDRESS 1302 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73974 D73974

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Presberterjian Eye - Ear St., Infant Hospital WARD)

2-FULL NAME Christopher Saunders.

(a) RESIDENCE NO. 405 S. Chapel ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Saunders.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Sturksen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sophia Zinksand (Sister)

(Address) 405 S. Chapel St.

15 MAR 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1923

17 I HEREBY CERTIFY, that I attended deceased from March 16 1923, to March 17 - 1923, that I last saw him alive on March 17 - 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Was a operation precede death? yes Date of Mar. 17-23

Was there an autopsy? No

What test confirmed diagnosis? Removal of growth

(Signed) E. A. Knott M. D.

, 19 (Address) 725 Fidelity Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: Mch 21st 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 400 S. Wolfe

CORONER FOR BALTIMORE EASTERN DISTRICT CITY-E...

Mar 19

Dr. Knott

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

Ashbury R. Hall ✓

D73975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73975

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ashbury Hall.

(a) RESIDENCE NO. 2208 E. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hall.

6 DATE OF BIRTH (month, day, and year) Oct 20 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Hall.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know.

14 Informant Mary Hall

(Address) 2208 E. Fayette St

15 MAR 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/7, 1922, to 3/19, 1923,

that I last saw him alive on 3/19, 1923,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Geo Gordon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakwood. DATE OF BURIAL Mch 20 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Fayette

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Rosie Bolbe

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73976
PLACE OF DEATH

CERTIFICATE OF DEATH.

31 D73976
REGISTERED No. C.....

CITY OF BALTIMORE (No. 634 Jasper St. St.; 17 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie Bolby

(Residence in Baltimore: No. 634 Jasper St. St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female | 4-COLOR OR RACE, colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, about ....., 1900
(Month) (Day) (Year)

7-AGE, 23 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country) Delaware, [redacted],

PARENTS.
10-NAME OF FATHER, [illegible]
11-BIRTHPLACE OF FATHER (State or Country). [illegible]
12-MAIDEN NAME OF MOTHER
13-BIRTHPLACE OF MOTHER (State or Country), [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Brown
(Address) 634 Jasper St.

15-
Filed MAR 20 1923 191. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 17 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pul. Tuberculosis
(Duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) X. T. Hennessy, M. D.
(Coroner.)
March 17 1923 (Address) 2512 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel, Delaware | DATE OF BURIAL, Mar. 20, 1923
20-UNDERTAKER Jno. M. Johnson | ADDRESS 1234 Ethel St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D73977 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-00 D73977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W. North Avenue ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie B. H. Pleasants

(a) RESIDENCE NO. 702 W. North Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Hungerford

11 BIRTHPLACE OF FATHER (city or town) Calvert Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Emma Burbridge

13 BIRTHPLACE OF MOTHER (city or town) Cumberland
(State or country) Maryland

14 Informant Mrs. William I. O'Neal
(Address) 702 W. North Avenue

15 Filed MAR 20 1923, ROBERT K. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 15, 1923, to Mch 18, 1923, that I last saw her alive on Mch 18, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Apl Hemiplegia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No —

What test confirmed diagnosis? Heat + acid

(Signed) Irvin Eshman M. D.

(Address) 700 W. N. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hyde German Lutheran Cemetery	3/20 23
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lakeland ST., ... WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME .....

(a) RESIDENCE No. ..... ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE ..... Years ..... Months ..... Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14

Informant .....
(Address)

15

Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19 .....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

D73979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 125 E. Birckhead St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Rogers.

(Residence in Baltimore: No. 125 E. Birckhead St. St.; yrs. 59 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Widower.

6-DATE OF BIRTH. Do not know. ..... 1..... (Month) (Day) (Year)

7-AGE. 59 yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Watchman.
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Rogers.

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Sarah E. Redmond.

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Murray. (sister)

(Address) 1309 Hanover St.

15- Mar 20 1923 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18th. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart and kidneys.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto A. Reinhardt M. D. (Coroner.)

Mch 19. 1923 (Address) 917 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	3/20/ 1923
20-UNDERTAKER. Wm. H. Hynes	ADDRESS. 1722 Eutaw St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73980

D73980

CERTIFICATE OF DEATH.

94

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Kate Ave St. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace May Whalen

(a) RESIDENCE. NO. 2603 Kate Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ellsworth Whalen

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Chapman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. R. Fuller Wright
(Address) 2414 W. Lanvale St.

MAR 20 1923 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17 I HEREBY CERTIFY, That I attended deceased from March 12 1923, to March 20, 1923, that I last saw h.r alive on March 21, 1923, and that death occurred, on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) E. N. Cole, M. D.

3/20, 1923 (Address) 13 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 20 1923
20 UNDERTAKER Jack B. Cook	ADDRESS 1063 N. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73981

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73981

CERTIFICATE OF DEATH

90

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 229 S. Calhoun St.; 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Dorothea Fischer

(Residence in Baltimore: No. 229 S Calhoun St.; 30 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Jan. (Month) 27 (Day), 1875 (Year)

7 AGE: 48 yrs. 1 mos. 18 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Milliner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Gustave Fischer

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Lindenbarth

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth Fischer
(Address) 229 Calhoun

15 Robert P. Harrison, Burial Permit Clerk — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mch 18 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1923, to Mch 8 1923, that I saw her alive on Mch 17, 1923 and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:

Pulmonary Disease of Heart

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Gustav Diel M. D.
Mch 9, 1923 (Address) 1433 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: London Park Cem. — DATE OF BURIAL: March 21, 1923

20 UNDERTAKER: William G. Schaeffer — ADDRESS: 816 Monument St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

220928

Spec.—1-10-21—M&T—1500 Blks.

D73982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73982

CERTIFICATE OF DEATH.

153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 S. Linwood ave. ST. 1 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Mc Donough

(a) RESIDENCE No. 1107 S. Linwood ave ST. 1 WARD *

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E. Mc Donough

6 DATE OF BIRTH (month, day, and year): Feb. 6 1864

7 AGE: Years 59 Months 1 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Martin Foley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah O'Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. E. Mc Donough 1107 S. Linwood ave

FEB 20 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 17 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to March 17, 1923.

That I last saw her alive on March 16, 1923.

And that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cellulitis (Streptococcus) of face & neck

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

3/20 1923 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Pius Cemetery

DATE OF BURIAL: 3/21 1923

20 UNDERTAKER: J. A. Moran

ADDRESS 3005 E. Baltimore St.

Registration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-2i—M&T—1500 Blks.

D73983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D73983

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 241 N. Bruce St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Enoch Peters

(a) RESIDENCE NO. 241 N. Bruce St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lelia Peters

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	50	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Butcher

(c) Name of employer Charles Lorman

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

PARENTS

10 NAME OF FATHER Joseph Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sy. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lelia Peters
(Address) 241 N. Bruce St.

15 Robert P. Harrison, Registrar
19
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/'23 19

17 I HEREBY CERTIFY, That I attended deceased from March 15th. 1923 to March 18th 1923, that I last saw him alive on March 18th. 1923 and that death occurred, on the date stated above, at 7.00 p.m.

The CAUSE OF DEATH* was as follows:

Acct. Parenchimatous Nephritis

Following exposure

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death No. Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis and Physical exam.

(Signed) Walter D. Jackson M. D.

19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 21 1923
20 UNDERTAKER	ADDRESS 1140 W. Lafayette Ave
Brown & Freeland	Schroeder

R 20 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D73984

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73984

CERTIFICATE OF DEATH.

47

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Gilbert ST., 16 WARD)

2-FULL NAME Virginia Smith

(a) RESIDENCE NO. 629 Gilbert ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE — Years: 65 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Willie Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Virginia Smith

(Address): 629 Gilbert

15 Filed ... 19... Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1922, to March 17, 1923, that I last saw h alive on March 17, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cancer Breast

(duration) yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary): Pulmonale

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J Hoswood, M. D.

19 (Address) 739 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Mar 21 1923

20 UNDERTAKER: Bonner Fleeland & Schenck — ADDRESS 1147 W

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D73985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73985

CERTIFICATE OF DEATH.

X 159-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrae Catravine Bakacs

(a) RESIDENCE NO. Dillonvill Rd, Ohio WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 1922

7 AGE — Years — Months 8 Days — If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) ... (State or country) W. Va.

PARENTS

10 NAME OF FATHER Andrae —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Catharine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant JOHNS HOPKINS HOSPITAL (Address) Texas

15 Filed ... 19 ... Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1923, to March 20, 1923, that I last saw h[illegible] alive on March 20, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of March 19

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Emil Holman M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dillonvale Ohio	March 1923
20 UNDERTAKER	ADDRESS
William Buck	626 E Nathan

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D73986

D73986

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lake Drive apt ST., 13 WARD)

2-FULL NAME Julia Hamburger

(a) RESIDENCE NO. Lake Drive apts ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myer Hamburger

6 DATE OF BIRTH (month, day, and year) May 18/1849

7 AGE — Years: 73 — Months: 10 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Samuel Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Francis Wertheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Hamburger
(Address)

15 Robert P. Harrison, 19...
Burial Permit Clerk. Registrar

201923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to March 19, 1923, that I last saw her alive on March 19, 1923, and that death occurred, on the date stated above, at 4.40 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Lentz, M. D.

3-19, 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levi Shalom — DATE OF BURIAL March 21, 1923

20 UNDERTAKER David Goodheim — ADDRESS 118 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73987

CERTIFICATE OF DEATH.

34 D73987

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 76 WARD)

2-FULL NAME William S. Logan

(a) RESIDENCE NO. 313 S. Highland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Wm S Logan

6 DATE OF BIRTH (month, day, and year) 1898 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Logan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Millie Arrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs J. Logan

(Address) 313 Highland Ave

15 Filed ..... 19..... Registrar Robert F. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/15, 1922, to 3/18, 1923, that I last saw him alive on 3-18-, 1923, and that death occurred, on the date stated above, at 4.45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Spondylitis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Milton C Lang M. D.

3/18 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dale Lawn Cemetery	March 21 1923
20 UNDERTAKER	ADDRESS
Geo M Zink & Son	811 N Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] is very important. See instructions on back of certificates.

20 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73988

CERTIFICATE OF DEATH.

11-001 D73988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1203 Valley ST., 10 WARD)

2-FULL NAME Edwin L. Brandt

(a) RESIDENCE NO. 1203 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) November 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John A. Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth H. Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr John A. Brandt

(Address) 203 Valley St

15 Filed MAR 21 1923 ROBERT R. KNAUER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1923 to Mar. 20, 1923.

that I last saw h alive on Mar. 20 1923

and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

(a) Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) J. W. Musgrave, M. D.

3, 20, 1923 (Address) 1206 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 22 1923
20 UNDERTAKER	ADDRESS
Henry Hoock Son	120 E Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73989

D73989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Eye Ear & Throat Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 625 W. Lanvale ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion G.a. Wise -

(a) RESIDENCE. No. - 211 - Hoodwood Gardens - Roland Park.
(Usual place of abode) ST.; WARD.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24th 1916

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Walter D Wise.

11 BIRTHPLACE OF FATHER (city or town) California
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes G. Whiting

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant W D Wise
(Address) 3209 N Charles St

15 Filed MAR 21 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16 - 1923. to - March 20. 1923.
that I last saw he alive on March 20 - 1923.
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

- Septic meningitis
(Streptococcus hemolyticus)

(duration) yrs. mos. 4 ds

CONTRIBUTORY (Secondary) Double Mastoiditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home Feb. 20, 23

Did an operation precede death? Yes Date of March 1/23

Was there an autopsy? No March 12/23

What test confirmed diagnosis? Spinal puncture

(Signed) James W Downey M. D.

(Address) 529 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	3-22 1923
20 UNDERTAKER Henry W. Jenkins Sons Co	ADDRESS Orchard & McCulloh

Duration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160

D73990

D73990

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2223 Choptank ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Salus

(a) RESIDENCE NO. 2223 Choptank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Salus'

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Pauline Skowronek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Pauline Salus' (Address) 2223 Choptank St

15 Filed MAR 21 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 20, 1923, that I last saw him alive on March 20, 1923 and that death occurred, on the date stated above, at 515 p m.

The CAUSE OF DEATH* was as follows:

Marasmus. (over)

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Kramer M. D.

(Address) 801 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	March 23 1923

20 UNDERTAKER John McWeber ADDRESS 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73991

CERTIFICATE OF DEATH.

74-001

D73991

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3311 First Ave Caston St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Frank Long.....

(a) Residence No. 3311 First Ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Long

6-DATE OF BIRTH (month, day and year) Jan 31, 1847

7-AGE. 76 yrs. 1 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 15 years

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, George Long

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Regina Ahern

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Mrs F. H. Keener

(Address) 3311 First Ave

15-

Filed MAR 21 1923 ROBERT R. KRAUTER Registrar.

ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from Feby 15th, 1923, to March 18th, 1923, that I last saw him alive on March 18th, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D W Jones, M. D

3/20/, 1923 (Address) 1111 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL, March 21, 1923

20-UNDERTAKER, L. Sander Sons ADDRESS 1710 Pratt St.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73992

CERTIFICATE OF DEATH.

D73992

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

2-FULL NAME Laura E Thompson

(a) RESIDENCE NO. Glenar, Balto Co., md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ... yrs. mos. 14 ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	B	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Co Va

PARENTS

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Co Va

12 MAIDEN NAME OF MOTHER Sophia Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Robt Jones

(Address) 1033 N Carey St

15 Filed MAR 2 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20- 1923

17

I HEREBY CERTIFY, That I attended deceased from 3-6- 1923, to 3-20- 1923,

that I last saw her alive on 3-20- 1923

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver & Gall Bladder

Cornic Hepatis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3-17-23

Was there an autopsy? no

What test confirmed diagnosis? Operation findings

(Signed) Newton D Parr, M. D.

3/24. 1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 24 1923
20 UNDERTAKER	ADDRESS
Emmert & Wright	1320 W Fayette

Burial Permit Clerk

INFORMATION, which should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73993

CERTIFICATE OF DEATH.

188-002

D73993

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Esau Jones

(Residence in Baltimore: No. 1402 Argyle Ave. St. (yrs. 25) mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	black	married

6-DATE OF BIRTH, ... unknown ..... 1..... (Month) (Day) (Year)

7-AGE. ..... 68 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpet Layer
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Georgia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country). H

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). H

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matilda Jones

(Address) 1402 Argyle Ave.

15- Filed MAR 21 1923 192 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18/23 (Month) (Day) 11.55 1923 P. M. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- struck by street car

(Fractured skull, jaw and crushed chest)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Koller (Coroner.) M. D.

3/20/23 (Address 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Lore	Mar. 24 1923
20-UNDERTAKER, James L. Burns	ADDRESS 308 Greenmount

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21-E.B.R.S.—400 Bks.

D73994 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D73994

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Williams

(a) Residence No. 1221 Smith St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 2

6-DATE OF BIRTH (month, day and year) 1872

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Peter Robinson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Nettie Blake

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 21 1923 ROBERT A. KNAUER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from February 13 19 23 to March 18 19 23.

that I last saw her alive on March 18 19 23.

and that death occurred, on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hart Failure

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. McKay M. D.

3-19 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn

DATE OF BURIAL. Mar. 21 19 23

20-UNDERTAKER. James F. Lewis

ADDRESS 1303 Druid Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73995

CERTIFICATE OF DEATH.

1-00 D73995

1-PLACE OF DEATH CITY OF BALTIMORE: (No. St. Joseph's Hosp ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert G. Lenze.

(a) RESIDENCE. No. 276 London ~~Street~~ WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 57 yrs. 11 mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Lenze

6 DATE OF BIRTH (month, day, and year) April 2nd 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Loudon Park Cemetery Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baden. Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Thurman Lenze
(Address) 276 London Ave

15 Filed MAR 21 1923 ROBERT A. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1922 to March 19, 1923.
that I last saw him alive on March 19, 1923.
and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Typhoid fever.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? S. & S. + Widal 1:10

(Signed) Henry J. Hahn, M. D.

, 19 (Address) 28 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Mar 22 19

20 UNDERTAKER F. B. Keppler ADDRESS 2236 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73996

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. 908 E. Lombard St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Elizabeth Taylor

(Residence in Baltimore: No. 908 E. Lombard St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, Married, Widowed, ~~or Divorced~~, (Write the word.): Widow

6-DATE OF BIRTH: March (Month) 4 (Day) 1861 (Year)

7-AGE: 62 yrs. - mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: John Ecton

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: not Known

13-BIRTHPLACE OF MOTHER, (State or Country): not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mollie Marshall

(Address) 908 E. Lombard St

15- MAR 21 1923 ROBERT R. KRAUTER,

2 Hest ..... 192.... Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 19 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... yrs. ..... mos. 6 hrs.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lloyd E. Norton M. D.
Coroner.

Mch 20 1923 (Address) Curtis Bay.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Mch 22, 1923

20-UNDERTAKER: J. & B. Cook — ADDRESS: 1003 W. Balto St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73997

CERTIFICATE OF DEATH.

100-001

D73997

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3331 Payne St. ST. 13 WARD)

2-FULL NAME Delia J. Daniels

(a) RESIDENCE NO. 3331 Payne St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Daniels

6 DATE OF BIRTH (month, day, and year) Feb. 4" 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER William F. Furney

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Sprinkles

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md.

14 Informant Mrs. Frances R. Krickbaum
(Address) Hillsdale, Md.

15 MAR 21 1923. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 20" 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1923. to March 21, 1923.
that I last saw h alive on March 19, 1923
and that death occurred, on the date stated above, at 7.18 A. m.
The CAUSE OF DEATH* was as follows:
Branched Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Wallace Darby M. D.

3/20/23 (Address) 3821 Dyrumple Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Mary's Cem. (Hampden.) DATE OF BURIAL March 23 23

20 UNDERTAKER Joseph L. D. Cook ADDRESS 1013 W. Balto St.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73998

CERTIFICATE OF DEATH.

101-001 D73998

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 N. Spring ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Taylor

(a) RESIDENCE. No. 1819 N. Spring ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Army Auto

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Henry Taylor
(Address) 1819 Spring st

15 FILED MAR 21 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 18, 1923, that I last saw him alive on Feb 18, 1923, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path. Exam.

(Signed) R. Gaylord Thomas M. D.

Feb 20 1923 Address) 1534 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorel Cemetery	Mar 19
20 UNDERTAKER Mrs. R. C. Ellis	ADDRESS Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73999

CERTIFICATE OF DEATH.

123

D73999

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 931 Wilmer Place ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanch Boarter

(Residence in Baltimore: No. 931 Wilmer Place St.; 7 yrs. ..... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March ..... (Month) ..... (Day) ....., 1895 (Year)

7-AGE, 28 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Alice Coleman

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..William A. Coleman

(Address)..931 Wilmer Alley

15-

Filed....., 191.....

MAR 21 1923

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 18 (Day) Sunday, 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 2nd 1923, to March 18 1923, that I saw h[illegible] alive on March 18 1923 and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

..... (Duration) ..... yrs. ..... mos. [illegible] ds.

CONTRIBUTORY (Secondary) Jaundice

..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Jas C Carpin M. D.

3-14 1923 (Address) 1063 Myrtle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residance .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Mar 22, 1923

20-UNDERTAKER Mrs R. C. Elliott

ADDRESS Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74000

CERTIFICATE OF DEATH.

X 90 D74000

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 W. Dallas ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Kellum

(a) RESIDENCE. NO. 611 W. Dallas ST., WARD Washington D.C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 3 mos. ✓ ds. How long in U. S., If of foreign birth? yrs. ✓ mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Kellum (Address) 611 W. Dallas St

15 Filed MAR 24 1923 . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1923, to Mar. 18, 1923, that I last saw h alive on mar 17, 1923 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Durand Fiske, M. D.

3/19. 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL Mar 24 1923

20 UNDERTAKER Mrs B a Elliott — ADDRESS 1925 a Gilmor Mar 24 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Sarah Flowers

(Residence in Baltimore: No. 1301 N Mount St., 52 yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH. Nov (Month) 12 (Day) 1871 (Year)

7-AGE. 51 yrs. 5 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private Family

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, James Nelson

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, Sophie Ward

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanch Makel

(Address) 1608 W Lanvale St

Filed MAR 21 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Severed Interstitial Jugular Vein
Self Inflicted Knife Wound

(Duration) ....yrs. ....mos. 25 Min.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M Fenton M. D. (Coroner.)

Mar 18 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos. In the City....yrs. 10 mos....ds.

Where was disease contracted, if not at place of death?..... Fremont Ave & Laurens St

Former or usual residence 1301 N Mount St.

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery DATE OF BURIAL. March 22 1923

20-UNDERTAKER. Robert L Packam ADDRESS 22 Hamburg St

STATE OF MARYLAND—Form of certificate to be filled out by physician, undertaker or person acting as undertaker. Name of informant should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74002

CERTIFICATE OF DEATH.

11-001 D74002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 E. Eager ST., 8 WARD)

2-FULL NAME Bertha Pollhammer

(a) RESIDENCE NO. 2326 E. Eager ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 54 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of HUSBAND of Anton Pollhammer

6 DATE OF BIRTH (month, day, and year) Aug. 14/1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Strodtke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anton Pollhammer (Address) 2326 E. Eager St.

15 MAR 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923 to March 19, 1923

that I last saw h[illegible] alive on March 19, 1923 at 1.30 p m.

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Findings + Pathological Appearance

(Signed) [illegible] M. D.

19 ..... (Address) 700 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 3/22 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

GIVE INFORMATION REQUESTED, PRINTING IN INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74003

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D74003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 S. Collington Ave. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Erlbeck

(a) RESIDENCE NO. 22 S. Collington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Erlbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Elizabeth -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Maggie Erlbeck

(Address) 22 S. Collington Ave

15 Filed MAR 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 22 1922, to Mar 19 1923, that I last saw h[e] alive on Mar 19 1923, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Febroid

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. F. Meyer Jr, M. D.

1923 (Address) 1638 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. F. Carmel

DATE OF BURIAL Mar 22 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74004

CERTIFICATE OF DEATH.

23 D74004

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Woodbourne Ave. ST., 27 WARD)

2-FULL NAME Helen J. Wisner

(a) RESIDENCE NO. 1001 Woodbourne Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER J. Grason Wisner

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Susan B. Gardner

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant J. Grason Wisner
(Address) 1001 Woodbourne Avenue

15 Filed MAR 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/16, 1923, to 3/19, 1923, that I last saw her alive on 3/19, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis (acute)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. W. [illegible], M. D.

3/20 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Druid Ridge Cemetery

DATE OF BURIAL
March 22 1923

20 UNDERTAKER
E. LeRoy Stiffler

ADDRESS
125 E. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on CAUSE OF DEATH in plain terms, so that it back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74005

CERTIFICATE OF DEATH.

90 D74005

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1612 N. Fulton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leona M. Shultz

(Residence in Baltimore: No. 1612 N. Fulton ave. St.; 42 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Feb. 8, 1856 (Month) (Day) (Year)

7-AGE: 67 yrs. 1 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Carroll Co, Md.

PARENTS.

10-NAME OF FATHER: Geo. Burns

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mandy Wentz

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. P. Shultz

(Address) 1612 N. Fulton Ave

15-ROBERT A. KRAUTER MAR 21 1923

Filed 191 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 18, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Organic heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

March 19 1923 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Western Cemetery

DATE OF BURIAL, March 24. 1923

20-UNDERTAKER, E. Le Roy Stiffler

ADDRESS 125 E. Madison ave

Spec.—1-10-21—M&T—1500 Bks.

D74006 HEALTH DEPARTMENT—CITY OF BALTIMORE D74006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH TOFT 118-00

CITY OF BALTIMORE: (No. 1618 Bolton St ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) 5 Town

2-FULL NAME Margaret A. Toft

(a) RESIDENCE NO. 1618 Bolton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lathom Toft

6 DATE OF BIRTH (month, day, and year) Oct 20 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William A. Small

11 BIRTHPLACE OF FATHER (city or town) Charleston (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Agnes F. Pentz

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Owen F. Keller (Address) 1615 Bolton St

15 Filed MAR 24 1923 Robert M. Knauer Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 15th, 1923, to Mch 19, 1923, that I last saw her alive on Mch 19, 1923; and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: Intramural fibroid of Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Grave

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Gilroy, M. D.

, 19 (Address) 1500 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Mar 23 1923

20 UNDERTAKER John B. Spence — ADDRESS 1325 N. Caroline St

ATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74007

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D74007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bowley's Lane near Franklin ST., 16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Franklin ave. Gardenville

2-FULL NAME Anna M. Zimmerman

(a) RESIDENCE No. Bowley's Lane near Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman J. Zimmerman

6 DATE OF BIRTH (month, day, and year) Dec. 31st 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Christian Deppish

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Germany

14 Informant Herman J. Zimmerman
(Address) Reisterstown Md.

15 MAR 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15th, 1923, to March 19, 1923, that I last saw her alive on March 19th, 1923, and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

To my knowledge (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Edw. W. Benson M. D.

3/24/1923 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 22, 1923
20 UNDERTAKER	ADDRESS
Fred'k Gaeschke & Son	Fullerton

*AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74008

REGISTERED NO. D74008

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 N Washington ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Jacobs

(a) RESIDENCE. NO. 1723 N Washington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sally D. Jacobs

6 DATE OF BIRTH (month, day, and year) July 6, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wilmington Del

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Mrs. Sally D. Jacobs 1723 N Washington St

15 Filed MAR 21 1923 19 ROBERT M. KRAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19- 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1923, to March 19, 1923, that I last saw h/m alive on March 19, 1923, and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) Jeanne Fowler, M. D.

19 (Address) 1506 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 3/21/1923

ADDRESS

20 UNDERTAKER: Edw. J. Fanning & Son 1938 E. Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. (or WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Handin

(a) RESIDENCE NO. 1070 Granby st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Handin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed MAR 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to March 21, 1923, that I last saw him alive on March 21, 1923, and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(duration) yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum X-ray

(Signed) Francis L. Ballenger M. D.

3-21, 23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Rosedale DATE OF BURIAL March 24 1923

20 UNDERTAKER Jack Levin ADDRESS 1497 E. Balto

N.B.—ENTRIES must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74010 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D74010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital, St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Gagneux

(a) Residence No. 224 22nd St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1848

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Elevator Operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Simon Gagneux

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 21 1923 ROBERT F. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 19, 1923

17- I HEREBY CERTIFY, That I attended deceased from January 29 19 23 to March 19 19 23

that I last saw h. in alive on March 19 to 23

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

3-20-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park	March 22 1923
20-UNDERTAKER.	ADDRESS
E A Weidefeld	501 E 22 St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74011

CERTIFICATE OF DEATH.

129 D74011

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura D Cooper

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD. Butler Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? 67 yrs. 0 mos. 0 ds.

should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	67	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Butler Pa.

PARENTS

10 NAME OF FATHER Jefferson McBride

11 BIRTHPLACE OF FATHER (city or town) (State or country) Butler Pa

12 MAIDEN NAME OF MOTHER Ellen Daley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Maine -

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md

15 MAR 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9th, 1921, to March 21, 1923, that I last saw h[illegible] alive on March 20, 1923, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis - with Uraemic Coma & Convulsions.

abt (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Butler Pa

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

. 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Butler - Butler Co. Pa.	March 21 1923

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AV

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74012 — CERTIFICATE OF DEATH. — 179 D74012

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mercy Hospital St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Henry Euston.

(a) Residence No. 406 N. Regester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): ? ? 1880

7-AGE: 42 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Do
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.
10-NAME OF FATHER: John Euston
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland
12-MAIDEN NAME OF MOTHER: Mary Gray
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14-(Informant): Milton Davis
(Address): 315 N. Eden St.

15-FILED: MAR 21 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 19 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 22 1923 to March 19 1923

that I last saw him alive on March 19 1923

and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac failure

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross Appearance

(Signed) J. J. Vandegrift M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel cemetery	March 22 1923
20-UNDERTAKER.	ADDRESS
Milton Davis	315 N Eden

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Nks.

D74013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74013

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 161 W. Biddle St. (WARD) 27

2-FULL NAME Amelia Gettier.

(a) RESIDENCE NO. 161 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced. (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F. Gettier

6 DATE OF BIRTH (month, day, and year) Jan 23 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm F. Pennington

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Penna

12 MAIDEN NAME OF MOTHER Amelia Lynch

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Interment (Address) Mt Olivet Cemetery

15 MAR 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Jany 19, 1923, to Mar 20, 1923.

that I last saw her alive on Mar 18, 1923,

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Peterson, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Mar 23
20 UNDERTAKER Wm Frank Ford & Son	ADDRESS 1 E Madison St

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 74-001

D74014

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. Central Ave. ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jones

(a) RESIDENCE. NO. 411 N. Central Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

50 yrs.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Carrie Jones

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Junk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Himself

9 BIRTHPLACE (city or town) (State or country): Frederick, Md.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Carrie Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Margaret Moore

(Address) 422 N. Dallas St.

15 MAR 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1923, to Mar. 19, 1923

that I last saw h alive on " " 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, arteriosclerosis, apoplexy.

The Nephritis lasted one year

insane and apoplexy about a day.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia, etc.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Typical.

(Signed) Dr. Wm. Fields Boyd, M. D.

1923 (Address) 401 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetry	Mar 22 19
20 UNDERTAKER: Mrs Robert & Elliott	ADDRESS 1723 Oakland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74015 HEALTH DEPARTMENT—CITY OF BALTIMORE D74015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1917 Edmondson Ave St. 20 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosina R. Eigenbrot

(Residence in Baltimore: No. 1917 Edmondson Ave St.; yrs. 46 mos. 10 ds. 0)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: May (Month) 19 (Day) 1876 (Year)

7-AGE: 46 yrs. 10 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of Industry, business, or establishment in which employed (or employer): Woman's Workmen

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Christian Eigenbrot

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Katherine Roos

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Catherine Meyer

(Address) 1917 Edmondson Ave

15- MAR 21 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 19 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

March 21 1923. (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Mar 22 1923

20-UNDERTAKER: W. J. Hickman & Sons — ADDRESS: Nork & Pa

21.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74016

CERTIFICATE OF DEATH.

90 D74016

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2906 Keyworth Ave ST., 15 WARD)

2-FULL NAME Emily Agnes Baker

(a) RESIDENCE NO. 2906 Keyworth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. H. Baker

6 DATE OF BIRTH (month, day, and year) May 1-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER John Hyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. May A. Barnicle

(Address) 2906 Keyworth Ave

15 Filed 2 1 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 5. 1923 to Mar 20 1923

that I last saw h alive on mar 20 1923,

and that death occurred, on the date stated above, at 6 0 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Case

(Signed) [illegible], M. D.

3/24 1923 (Address) 1857 Pa Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kemptown. Frederick Co Md

DATE OF BURIAL Mar 27 1923

20 UNDERTAKER Wm J Tickner & Sons

ADDRESS N. Y Pa

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74017

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74017

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Cole ave ST., 26 WARD)

2-FULL NAME Doris L. Oehm

(a) RESIDENCE No. 210 Cole ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wh	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) B

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Fred. H. Oehm

11 BIRTHPLACE OF FATHER (city or town) Balto,
(State or country)

12 MAIDEN NAME OF MOTHER Doris Cardwell

13 BIRTHPLACE OF MOTHER (city or town) Balto,
(State or country)

14 Informant Fred H. Oehm
(Address) 210 Cole ave

MAR 21 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1923, to Mar 20, 1923, that I last saw h[illegible] alive on Mar 20, 1923, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical Signs

(Signed) [illegible], M. D.

3/20, 1923 (Address) Maplewood, Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Mar 23 1923
20 UNDERTAKER	ADDRESS
Furkler & Furkler	1739 Eagan

REMARKS.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74018 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D74018

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1103 So. Kenwood St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Waligorski

(Residence in Baltimore: No. 879 So. Milton Ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. July 9th 1899
(Month) (Day) (Year)

7-AGE. 27 yrs. 8 mos. 10 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Bacto. Md

PARENTS.

10-NAME OF FATHER. John Waligorski

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Elizabeth Oltman

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Signed) Elizabeth Waligorski

1103 So. Kenwood ave

Robert P. Harrison, 192.....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 19th 192 3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. P. Holland M. D.
(Coroner)

Mch 20 192 3 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus Kostka Cem. DATE OF BURIAL. Mar. 22. 1923

20-UNDERTAKER. Stephen Stackowsky ADDRESS 100 Spencer

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74019

CERTIFICATE OF DEATH.

90 D74019

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1545 N Fremont Ave ST. 14 WARD)

2-FULL NAME William E Feldmon

(a) RESIDENCE NO. 1545 N Fremont Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER James H Feldmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mary Feldmon (Address) 1545 N Fremont Ave

15 Filed MAR 21 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1923, to Mar 20, 1923, that I last saw him alive on Mar 20, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

3/21, 1923 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL Mar 23rd 1923

20 UNDERTAKER Hammett & Wright — ADDRESS 1136 W Cary St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

GERSTUNG ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74020 124 D74020

D74020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH CITY OF BALTIMORE: (NO.) St Joseph's Hospital ST.; (WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Gerstung

(a) RESIDENCE. NO. 2708 Orleans ST., WARD. 32
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ——yrs. ——mos. ds. How long in U. S., if of foreign birth? 32 yrs. —— mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Gerstung

6 DATE OF BIRTH (month, day, and year) April 2 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER Herman Pechel
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Gerstung
(Address) 2708 Orleans st

15 Filed MAR 21 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 19, 1923, that I last saw her alive on March 19, 1923, and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... mos. ... ds.

CONTRIBUTORY (Secondary) Coronary Embolism (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 8/23

What test confirmed diagnosis? Clinical Features

(Signed) J W Bowers M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 22nd 1923
20 UNDERTAKER	ADDRESS
Geo Lindbach & Son	6711 Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICAL TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74021

129

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No.) Mercy Hospital St. 12 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Campbell

(a) Residence No. 114 E 30th St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ? ? 1849

7-AGE, 73 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Book-keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Md.

PARENTS.

10-NAME OF FATHER, Thomas Campbell

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country) Md.

12-MAIDEN NAME OF MOTHER, Catherine Lindsell

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country) Md.

14- (Informant) Mercy Hospital Records
(Address)

15- Robert P. Harrison,
Filed MAR 21 1923 192 Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 20 23

17- I HEREBY CERTIFY, That I attended deceased from March 3 1923 to Mar. 20 19 23
that I last saw him alive on Mar 19 19 23
and that death occurred, on the date stated above, at 1.50 P.M.
The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis
(Duration) 2 yrs. mos. ds
CONTRIBUTORY (Secondary) Uraemia Hypostatic Pneumonia (Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. J. Kane of Jr. M. D.
, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery
DATE OF BURIAL. 3/22, 19 23

20-UNDERTAKER. Henry W. Mears & Son
ADDRESS 805 N. Calvert

NO. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D74022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74022

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lola V. Masson

(a) Residence No. 807 University Parkway Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 24 72

7-AGE. 50 yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Home
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER, John Masson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore, Md

12-MAIDEN NAME OF MOTHER. Sarah Andrea

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) Mercy Hospital
(Address).....

15- Robert P. Harrison, Registrar.
MAR 21 1923 192.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 19, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 5, 1923 to March 19, 1923 that I last saw he alive on March 19, 1923 and that death occurred, on the date stated above, at. 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Cholecystectis
Cholelithiasis
Pericarditis
Unknown (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Pericarditis
(Duration) ...yrs. ...mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of March 16 23
Removal Gall Bladder

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) K. W. McCay M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Green Mount Cemetery	3/22 1923
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

B—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74023

CERTIFICATE OF DEATH.

49 D74023

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1760 Homestead, ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Gaskins.

(a) RESIDENCE. No. 1760 Homestead ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Gaskins

6 DATE OF BIRTH (month, day, and year) May 28 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57.	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John R Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Seibert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John L Strohmer 1760 Homestead St

MAR 21 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22 to March 19 1923.

that I last saw h alive on March 19 1923.

and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma - Breast.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. Schmuck M. D.

(Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer.	3-22 1923
20 UNDERTAKER	ADDRESS
E & B Hale	115 E Madison

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74024

CERTIFICATE OF DEATH.

31 D74024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2923 Riggs Ave. St., 16 WARD)

2-FULL NAME Chas. J. Sydings

(a) RESIDENCE NO. 2923 Riggs Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of Industry, business, or establishment in which employed (or employer) Stub. 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Chas. Sydings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary Hannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Thiel
(Address) 2923 Riggs Ave.

15 Filed MAR 21 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1922 to March 19, 1923.

that I last saw h[illegible] alive on March 19, 1923

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no Physical Exam

What test confirmed diagnosis?

(Signed) John A. Phalan M. D.

Mar 21, 1923 (Address) 1219 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cemetery DATE OF BURIAL Mar 22nd 1923

20 UNDERTAKER C. D. Fanning & Son - 1938 E. Lafayette Ave ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Worthington)

D74025

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D74025

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1050 W Barre st. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hobart Worthington

(Residence in Baltimore: No. 1050 W Barre st. St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Wife

6-DATE OF BIRTH: Oct (Month) 3 (Day) 1857 (Year)

7-AGE: 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment In which employed (or employer):

9-BIRTHPLACE, (State or Country): Washington DC.

PARENTS.

10-NAME OF FATHER: Geo Worthington

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Elz Harwood

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Worthington

(Address) 1420 Baltart

15- Filed MAR 21 1923, 192... Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) W K Goamach M. D. (Coroner.)

3.21. 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: 3/22 1923

20-UNDERTAKER: Wm Cook — ADDRESS: 500 E Northlane

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74026

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. on street at 735 W. Lexington St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John R. Calvert

(Residence in Baltimore: No. 735 W. Lexington St. St., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH.
....., 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
81 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Granite Cutter
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Balt city

PARENTS.
10-NAME OF FATHER. Jas. L. Calvert
11-BIRTHPLACE OF FATHER. (State or Country). Md
12-MAIDEN NAME OF MOTHER. McKinnon
13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carrie B. Calvert
(Address) 735 W Lex

15-
MAR 21 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 21, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

dont Know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) dont Know (Duration) yrs. mos. ds.

(Signed) H K Gannon M. D.
(Coroner.)

3. 21. 1923 (Address) 117 W Lanvale St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	9/24/ 1923
20-UNDERTAKER.	ADDRESS
Wm Cook	502 E Baltimore

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74027 90 D74027

CERTIFICATE OF DEATH.

D74027

1-PLACE OF DEATH Boy Jew Hospital

CITY OF BALTIMORE, (No. 15 ST. WARD)

2-FULL NAME Mathilda Londoner

(a) RESIDENCE NO. 1846 Aisquith St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md. U.S.

PARENTS

10 NAME OF FATHER Moritz Londoner

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Jane Lefren

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Mrs Londoner

(Address) Hebrew Home

15 Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1923, to March 20, 1923

that I last saw h[illegible] alive on March 20, 1923

and that death occurred, on the date stated above, at 8 30 9 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Melancholia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Todd Smith, M. D.

, 19 (Address) Boy Jew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew — DATE OF BURIAL March 23 1923

20 UNDERTAKER A Ahrens & Co — ADDRESS 1611 Mad ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74028

CERTIFICATE OF DEATH.

74-001 D74028

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 Bayard ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Parker

(a) RESIDENCE. No. 1222 Bayard ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Parker

6 DATE OF BIRTH (month, day, and year) Centemyer

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosa Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah Parker
(Address) 1222 Bayard St

15 Filed MAR 22 1923 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1923, to Mar 20, 1923, that I last saw him alive on Mar 20, 1923, and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Whitridge Hoag, M. D.

3/20 1923 (Address) 729 Cath. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 23 19
20 UNDERTAKER	ADDRESS 142
Jno. A. Joseph	Wkill St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74029

CERTIFICATE OF DEATH.

31 ✓ D74029

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Kotrow (Elizabeth Papilon)

(a) RESIDENCE No. 1419 Cooksey st, Locust Pt. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Papilon

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Thomas Shank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Madeline Helfrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Hospital Records

(Address) M.T.H.

15 FILED MAR 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1922, to March 21, 1923, that I last saw her alive on March 21, 1923, and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Fehsenfeld, M. D.

3-21-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.A.,	March 23 19 23
20 UNDERTAKER	**ADDRESS**
John Greblauckas	495 E. Paca st

D74030 HEALTH DEPARTMENT—CITY OF BALTIMORE D74030

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 808 E Pratt St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Leo Rossi-
808 E Pratt

(Residence in Baltimore: No. 808 E Pratt St.; yrs....mos....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.): Single

6-DATE OF BIRTH: March 12 (Month) (Day) 1885 (Year)

7-AGE: 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country): Italy.

PARENTS.

10-NAME OF FATHER: Leo Rossi

11-BIRTHPLACE OF FATHER, (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E E Johnson

(Address) 1413 Eastman ave

15-MAR 22 1923 ROBERT R. KRAUTER,

Filed ..... 192.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: March 17 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

(Duration) yrs. 2 mos. 3 wks. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Geo Edelson M. D.
(Coroner.)

March 19 1923 (Address) 143 - N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Vincent Cemetery	March 22 1923

20-UNDERTAKER.	ADDRESS
Geo. J. Ruth	1735 Harford ave.

Spec.—1-10-21—M&T—1500 Bks.

July 4 –

D74031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D74031

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Boy Jew Hospital

CITY OF BALTIMORE: (No. ..... ST. 24 WARD)

2-FULL NAME Sarah Abey

(a) RESIDENCE NO. 1407 Mcbolton ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5yr yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

George Levy

6 DATE OF BIRTH (month, day, and year) 7/4 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83 - 72	8.	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Ditto

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Do

(State or country)

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) Do

(State or country)

14 Informant Boy Jew Hospital

(Address) Balto, Md.

15 MAR 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1921, to March 20 1923

that I last saw her alive on March 20 1923

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Dementia + Delirium Tr

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical + symptoms

(Signed) N. Edwards M. D.

, 19 (Address) Boy Jew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL 3/23 19 23

20 UNDERTAKER William H Higdon

ADDRESS Berea

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74032

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Richard Taylor

(a) RESIDENCE No. 1626 Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	80	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caretaker

(b) General nature of Industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Va.

PARENTS

10 NAME OF FATHER T. Landon Taylor

11 BIRTHPLACE OF FATHER (city or town) (
(State or country)

12 MAIDEN NAME OF MOTHER Anna Rosse

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Wards

15 Filed MAR 22 1923, 19..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1923

17 I HEREBY CERTIFY, That I attended deceased from March 13th, 1923, to March 19, 1923,
that I last saw h.... alive on, March 19, 1923,
and that death occurred, on the date stated above, at 6.25 a.m.
The CAUSE OF DEATH was as follows:
(a) Lobar Pneumonia

(duration) ..... yrs. mos. 14 ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? Yes.
What test confirmed diagnosis? .....

(Signed) Chas. R. Bagley M.D.
Address Johns Hopkins Hospital
. 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover Co. House | DATE OF BURIAL 3/22/23

20 UNDERTAKER Edward F. Hemsley | ADDRESS 178 N. Eden

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74033

CERTIFICATE OF DEATH.

185 D74033

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 21 WARD)

2-FULL NAME John A Griesacker

(a) RESIDENCE NO. 1056 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1886 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) B & O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John A. Griesacker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Shaub

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. John A. Griesacker

(Address) 1056 W Barre St

15 MAR 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20th 1923.

17 I HEREBY CERTIFY, That I attended deceased from 8-19, 1922 to 3-20, 1923, that I last saw him alive on 3-20, 1923, and that death occurred, on the date stated above, at 10 05 A m.

The CAUSE OF DEATH* was as follows:

Fracture of 5th, 6th & 7th cervicale vertebrae

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Milton C. Lang, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar 23 1923.
20 UNDERTAKER John T. Gleason & Son	ADDRESS 901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PENCIL should not be used. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D74034

CERTIFICATE OF DEATH.

D74034

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frank King.

(a) Residence No. Bay View Asylum. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 35 ? yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Washington, D.C.
(State or Country),

PARENTS:

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town). ?
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). ?
(State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 19, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 16 19 23 to March 19 19 23

that I last saw h. in alive on March 18 19 23

and that death occurred, on the date stated above, at 1:10 A.M.

The CAUSE OF DEATH* was as follows:

Generese Pneumonia

(Duration) 5 yrs. mos. days

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. A. McKay M. D.

3-19-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

For Wm. F. WOODALL Commissioner Health. MAR 21 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK. Items 1 to 20 inclusive must be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

95

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74035 — 31 — D74035

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., (or) WARD)

2-FULL NAME. Nick Chomicz

(a) RESIDENCE No. 401 S. Bond st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not given

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Gregory Chomicz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mary Strok

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Records

(Address) M. T. H.

15 MAR 22 1923 — ROBERT R. KRAUTER, Registrar

Per Wm. E. Woodall, Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1923, to March 16, 1923, that I last saw him alive on March 16, 1923, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Lung abscess

(duration) yrs. 1 mos. 14 ds.?

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Minor Date of Mch. 15, '23

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum

(Signed) Frances L. Dalaplaine M. D.

3-17-23 (Address) Muni cipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health. — ADDRESS MAR 21 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Size—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D74036

D74036 CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Walter Woodward

(a) Residence No. 605 Asquith St. St, Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1885

7-AGE.	If LESS than 1 day,
37 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). O'Neil

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). South Carolina

PARENTS.

10-NAME OF FATHER. West Woodward

11-BIRTHPLACE OF FATHER (city or town) (State or Country). South Carolina

12-MAIDEN NAME OF MOTHER. Frances Wedlock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). South Carolina

11- (Informant) Municipal Hospital Record

(Address)

13- Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 16, 1923

17- I HEREBY CERTIFY, That I attended deceased from January 18, 1923 to March 16, 1923

that I last saw h. im alive on March 16, 1923

and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Ruptured aortic Valve

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

3-17-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19....
UNIVERSITY OF MARYLAND	
20-UNDERTAKER. Commissioner Health.	ADDRESS MAR 21 1923

Per. Wm. E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

95

Spec—12-23-21—E.B.R.S.—400 Pds.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74037

CERTIFICATE OF DEATH.

90 D74037

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Maggie Dennis.....

(a) Residence No. 405 N. Rose St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1862

7-AGE.	If LESS than 1 day,
60 ? yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town)..... ? (State or Country).

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town)..... ? (State or Country).

14- (Informant) Municipal Hospital Records.

(Address).....

15- Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 19, 19 23 to March 20, 19 23

that I last saw h.er alive on March 19, 19 23

and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:-

Heart Failure

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? yes

What test confirmed diagnosis?.....

(Signed) J. C. McKay M. D.

3-22, 19 23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Mathew Cem	Mar 22 19 23
20-UNDERTAKER. Jas C. Miller	ADDRESS 2334 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74038 23 D74038

CERTIFICATE OF DEATH.

D74038

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 N Montford ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rose Skrabels

(a) RESIDENCE. NO. 807 N. Montford ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Apl 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Making

(b) General nature of industry, business, or establishment in which employed (or employer): 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Frank Skrabels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Caroline Kuzicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Caroline Kuzicka (Address) 807 N Montford Av

15 Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923 to March 20 1923.

that I last saw h alive on March 20 1923

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Sleeping Sickness Following Grippe 2 yrs ago

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) J. J. Kelly Kingsbury, M. D.

3-24 19 (Address) 800 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 24 1923

20 UNDERTAKER: Frank L Crouch Son

ADDRESS: 1906 Eastland Av

THIS IS A PERMANENT RECORD—WRITE WITH UNFADING INK—THIS CERTIFICATE must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

D74039

CERTIFICATE OF DEATH.

D74039

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2446 Eager Place ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vaclav Skarda

(a) RESIDENCE. NO. 2446 Eager Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Skarda

6 DATE OF BIRTH (month, day, and year) Apr 1 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Meter Dept

(c) Name of employer B & O

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Skarda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Elsie Skarda

(Address) 2446 Eager Place

15 Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1923

17 I HEREBY CERTIFY, That I attended deceased from March 2 1923 to March 20 1923 that I last saw him alive on March 19 1923 and that death occurred, on the date stated above, at 10.25 A m.

The CAUSE OF DEATH* was as follows:

Grippe

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds. 4

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) F F Frey Dunaska M. D.

3 24 23 (Address) 700 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Mar 24 1923
20 UNDERTAKER	ADDRESS
Frank Enoch Son	1916 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D74040 HEALTH DEPARTMENT—CITY OF BALTIMORE D74040

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Reahl "Paul J. Reahl"

(a) Residence No. Unknown St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ?

7-AGE,	If LESS than 1 day,
61 yrs. ? mos. ds.	hrs. or. min. ?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto ? Md

PARENTS.

10-NAME OF FATHER, Wm Reahl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown ?

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto ?

14-

(Informant) Municipal Hospital Records

(Address)

MAR 22 1923 Filed 192 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 19, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 17, 1923 to March 19, 1923

that I last saw him alive on March 19, 1923

and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) atherosclerosis

(Duration) V yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. Mecray M. D.

3-20-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1923
Holy Redeemer	March 24
20-UNDERTAKER,	ADDRESS
Merriam Cook	502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY, in plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE OF DEATH instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—4-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74041 ×38 D74041

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Howard & Jessup ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter S Brown

(a) RESIDENCE NO. [redacted] Lake Shore Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. INFORMATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 3-15 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	~~1869~~			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) C&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Thomas a Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Rollison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Brown (Address) 1114 N. Fayette St

15 Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21- 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/14, 19...., to March 21. 1923.

that I last saw h[redacted] alive on 3/21 .1923,

and that death occurred, on the date stated above, at 12-30 P m.

The CAUSE OF DEATH* was as follows:

Aneurysm of Arch of Aorta

Ruptured

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....(duration) ....yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Leon Freedman, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL 3/24 1923

20 UNDERTAKER Wm Cook. — ADDRESS 502 E North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 D74042

D74042

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marrow Hospital ST., 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Boettger

(a) RESIDENCE NO. 1040 Forestville Blvd ST. N Y WARD Brooklyn N Y
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U. S., if of foreign birth? Entire mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seafaring 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Patient's History
(Address)

15 MAR 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-14, 1922, to 3-19, 1923.

that I last saw him alive on 3-19, 1923

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Exp. of Sputum Ex

(Signed) P. E. Schools M. D.

3/20, 1923 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	3/21/1923
20 UNDERTAKER	ADDRESS
J. Slinson & Bro	E. Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74043

CERTIFICATE OF DEATH.

++ D74043

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) Maryland General Hosp (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ragna Kluver

(a) RESIDENCE NO. 3026 E. Balto. ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. B. Kluver

6 DATE OF BIRTH (month, day, and year) aug-20-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Bernt Flossum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway.

14 Informant E. B. Kluver (Address) 3026 E. Baltoh

15 Filed MAR 22 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 17, 1923, to Mar 19, 1923, that I last saw h[illegible] alive on Mar 19, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Probably Cancer Liver

(duration) dont know mos ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) C. Scott Insley, M. D.

(Address) 2738 S. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy	3/22nd 1923
20 UNDERTAKER J. A. Moran	ADDRESS 300 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE ABOVE. PHYSICIANS should state age should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74044

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3327 Myrtle Place ST., No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Martinuzzi

(a) RESIDENCE NO. 3327 Myrtle Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Martinuzzi

6 DATE OF BIRTH (month, day, and year): Jan 23 1873

7 AGE: Years 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Granite-Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 076

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Peter Martinuzzi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosa Martinuzzi

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: John Martinuzzi

(Address) 3927 Myrtle Place

15 Filed MAR 2,2 1923 ROBERT R. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/20 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/19, 1923, to 3/20, 1923, that I last saw him alive on 3/20, 1923, and that death occurred, on the date stated above, at 12 30 Am.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

as Pulmonary Edema

(duration) yrs. mos 8hs. ds.

CONTRIBUTORY (Secondary) Bright's Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Wales, M. D.

3/21, 1923 (Address) 3323 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 3/23 1923

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74045

CERTIFICATE OF DEATH.

3 / D74045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 578 Preston St ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jamie Peterson

(a) RESIDENCE. No. 578 Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or)~~ WIFE of Samuel Peterson

6 DATE OF BIRTH (month, day, and year) June 9th 1886

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
36	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Edward Simms

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary E. Wright

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Maryland.

14 Informant Samuel Peterson
(Address) 578 W Preston St

15 Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20. 1923

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 1923, to March 20, 1923, that I last saw her alive on March 19th, 1923, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Neuritis

(duration) yrs. 2. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No History

What test confirmed diagnosis? Clinical findings

(Signed) Bunnell Sharpe, M. D.

, 19 (Address) 746 Dolphin St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Mar 25th 1923
UNDERTAKER Jno. M. Johnen	ADDRESS 1234 Ecting St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Pack

D74046

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

113 D74046

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1417 Laurens St, ST.: 16 WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Pack

(Residence in Baltimore: No. 1417 Laurens St, St.; yrs., 4 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, Nov. 11, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none,
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Jason A. Pack.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Carrie Gray

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jason A. Pack

(Address) 1417 Laurens St.

15- MAR 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 20, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.
thereon and from the evidence obtained by said ...
(Inquest, au
Inquiry ....find that said deceased came to his death
(Autopsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration).....yrs.....mos. 14 ds.

CONTRIBUTORY (Secondary) Burned - pneumonia

(Duration).....yrs.....mos. 3 ds.

(Signed) J. J. T. Hennessy M. D.
(Coroner.)

March 21, 1923 (Address) 200 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Mar. 22 1923
20-UNDERTAKER Wm. J. Dunn	ADDRESS 1319 Druid

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.F.S.–400 Blks.

D74047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74047

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jennie Levin

(a) Residence No. 942 Pearl St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Levin

6-DATE OF BIRTH (month, day and year) Dec 12 1867

7-AGE, 55 yrs. 3 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Sam Rickelson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Jennie Rickelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Next of Kin

(Address)

15-Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 22 '23

17- I HEREBY CERTIFY, That I attended deceased from Dec 29. 19 22 to Mar 22, 19 23

that I last saw h.. alive on Mar 22 19 23

and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sign & Symptoms

(Signed) M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 3/23 19 23

20-UNDERTAKER, Jos. Levin — ADDRESS 1439 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74048 — 31 — D74048

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 541 N. Pulaski St. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarissa Price Jordan

(a) RESIDENCE NO. 541 N. Pulaski St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Preston W. Jordan

6 DATE OF BIRTH (month, day, and year) Jan. 6" 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Richard C. Emerick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Pauline Meeks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Preston W. Jordan 541 N. Pulaski St.

15 MAR 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 21" 1923

17

I HEREBY CERTIFY, That I attended deceased from Jany. 21, 1923, to Mar 20, 1923.

That I last saw her alive on March 20, 1923

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal & Pulmonary Tuberculosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myer A. Weinberg, M. D.

3/21 19 23 (Address) 1724 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mar 23" 1923
20 UNDERTAKER: Joseph D. Cook	ADDRESS: 1003 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74049 ✓

D74049

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 W Fayette ST. 4 WARD)

2-FULL NAME Annette E Pultz

(a) RESIDENCE NO. 722 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hiram L Pultz

6 DATE OF BIRTH (month, day, and year): June 21 1839

7 AGE: Years 83, Months 9, Days 0; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Jacob L Pultz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Dreidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant (Address): Wm Emachel 722 W Fayette

15 MAR 22 1923 ROBERT K. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 — 1922, to Mar 21 1923, that I last saw h e alive on Mar 19 — 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Hemiplegia

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Advanced age & arteriosclerosis (duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam.

(Signed) Chas J Keller M. D.

Mar 24 1923 (Address) 222 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenbeck Cemetery Newport DATE OF BURIAL: 3/22 1923

20 UNDERTAKER: L C Tuscarbough ADDRESS: 2620 St Paul

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST NOT BE FOLDED. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10 21—M&T—1500 Blks.

D74050

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D74050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 45 Maryland Ave (If not in hospital, give STREET or AVENUE) Westport WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George William Geis

(a) RESIDENCE No. 45 Maryland Ave (Usual place of abode) Westport WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced (for) HUSBAND of / WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 25 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Wholesale Grocery Business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George P. Geis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hurchert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary P. Geis (Address) 45 Md. Ave Westport

15 MAR 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to Feb 20, 1923, that I last saw him alive on Feb 20, 1923, and that death occurred, on the date stated above, at 1 45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Alan B Lemon M. D.

3/22/1923 (Address) 718 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Mar 23 1923
20 UNDERTAKER	ADDRESS
H. Olander & Sons	1710 Flint St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this certificate should be carefully answered. If the information should be stated EXACTLY. PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74051

CERTIFICATE OF DEATH.

101-001

D74051

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 16 WARD)

2-FULL NAME Orma E Bowen

(a) RESIDENCE NO. 2714 Harlem Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26. 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	6	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward E. Bowen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katie A. Dalrymple

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Edward E. Bowen
(Address) 2714 Harlem Ave.

15 Filed MAR 22 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1923

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to Mch 21, 1923.

that I last saw h[illegible] alive on Mch 21 1923

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bilateral Lobar,

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Peritonitis General

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Mch 20 '23

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Cayetano Ramirez M. D.

Mar. 21 1923 (Address) Church Home and Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL MAR 24 1923

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54 D74052

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Burns

(a) Residence No. 804 S. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1869

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Boston, Mass.

PARENTS.

10-NAME OF FATHER, Luke Burns

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Sullivan

13-BIRTHPLACE OF MOTHER (city or town) Boston, (State or Country), Mass.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 19 Robert P. Harrison, Registrar.

MAR 22 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from October 19 1922 to March 18, 1923

that I last saw him alive on March 18, 1923

and that death occurred, on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH* was as follows:

Pellagra

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

3-19-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS MAR 22 1923

Commissioner Health,

For Wm. F. Mc[illegible]

B—WRITE PLAINLY. WORDS should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74053

CERTIFICATE OF DEATH.

101-001

D74053

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Lemon ST., 18 WARD)

2. FULL NAME Geo. W. Sharetts

(a) RESIDENCE NO. 914 Lemon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
-	74?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Solicitor

(b) General nature of industry, business, or establishment in which employed (or employer) Newspaper

(c) Name of employer Union Leader

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm L. Sharetts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Minnie Mitchell

(Address) Robert T. Harrison,

15 [illegible] 19.....

MAR 22 1923 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/23 19

17

I HEREBY CERTIFY, That I attended deceased from 3/18/23, 19..., to 3/21/23, 19...,

that I last saw h— alive on 3/21/23, 19...,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 914 Lemon

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Bernard H. Long, M. D.

3/24, 1923 (Address) 714 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Cemetery	3/25 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 Brantwood

MAR 22 1923

UNIVERSITY OF MARYLAND

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74054

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 643 W. Fayette St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Infant of Samuel & Elizabeth Dougherty

(a) Residence No. 643 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	W	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 3/20/23

7-AGE. ....yrs. ....mos. 2 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balt

PARENTS.

10-NAME OF FATHER. Samuel Dougherty

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Oklahoma

12-MAIDEN NAME OF MOTHER. Elizabeth Harrison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant).

(Address).

15- Filed ....., 19?. Registrar.

Robert P. Harrison, Burial Permit Clerk.

MAR 22 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/21/23

17- I HEREBY CERTIFY, That I attended deceased from 3/20/, 19 23, to 3/21/, 19 23

that I last saw h— alive on 3/21/, 19 23

and that death occurred, on the date stated above, at 8.25 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(7 month pregnancy)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry H. Weinberger M. D.

3/22, 19 23 (Address) 724 W. Lafayette Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL. | DATE OF BURIAL, ..., 19..

20-UNDERTAKER. Commissioner Health. | ADDRESS MAR 22 1923

For Wm. F. WOODALL

WHITE PENCIL, WITH ONE BLOW, WILL MAKE 4 COPIES. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very Important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

D74055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ Dr Hennessy
Edmondson Ave

185 D74055

Registered No. C.....

1-PLACE OF DEATH City of BALTIMORE: (No. 7 Maryland Lee Hospital 90 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Boggs

(Residence in Baltimore: No. 1203 Walden Ave. St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: January 31 (Month) (Day) 1849 (Year)

7-AGE: 74 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Virginia

PARENTS:

10-NAME OF FATHER: Thos. Boggs

11-BIRTHPLACE OF FATHER, (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Susan Chandler

13-BIRTHPLACE OF MOTHER, (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margie E. Boggs

(Address) 1263 Walden Ave

15- Robert P. Harrison, 192..... Registrar.
~~Burial Permit Clerk.~~

MAR 22 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~inquiry~~ (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Fell out of window

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

March 22 192 3 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	3/24 1923
20-UNDERTAKER, Wm Cook	ADDRESS 502 E North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74056

CERTIFICATE OF DEATH.

D74056

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1322 S. Carey St. 21; St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie F. Butler

(a) Residence No. 1322 S. Carey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James E. Butler

6-DATE OF BIRTH (month, day and year) Feb 8 1887.

7-AGE, 36 yrs. 1 mos. 13 dys. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Cambridge Md

PARENTS.

10-NAME OF FATHER, Wm. R. Sinclair

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Martha Quarles

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) James E. Butler

(Address) 1322 S. Carey St.

15-

Filed.....Robert P. Harrison, Registrar.

MAR 22 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 21-1923

17- I HEREBY CERTIFY, That I attended deceased from 3/16/23, 19....., to 3/21/23, 19....., that I last saw h[illegible] alive on 3/21/23, 19....., and that death occurred, on the date stated above, at 10.50 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis pulmonary

(Duration) ....yrs. ....mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

3/22/23 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL. March 23 1923

20-UNDERTAKER. John O. Mitchell ADDRESS 3 [illegible] St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74057 ✓ 46 D74057

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 706 Reservoir ST. 13 WARD)

2-FULL NAME Carolyn Montgomery Sanders.

(a) RESIDENCE NO. 706 Resivoir St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Thomas D. Sanders.

6 DATE OF BIRTH (month, day, and year) 1-20-1877

7 AGE: Years 46 Months 2 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Jersey.

PARENTS

10 NAME OF FATHER James Montgomery.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Mary E. Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant (Address): Mrs. Ceo. Valentine 706 Reservoir St

15 Filed APR 22 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1921, to March 21, 1923,

that I last saw her alive on March 20, 1923,

and that death occurred, on the date stated above, at 10.20 A. m.

The CAUSE OF DEATH* was as follows:

Adeno-papilla carcinoma of left ovary - with metastases in abdomen cavity.

..... (duration) 1 yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? Yes. Date of Apr 5, 1922

Was there an autopsy? No

What test confirmed diagnosis? Examination of tissue

(Signed) Harry D. McCarty, M. D.

3-21, 1923 (Address) 67 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Mar 23 / 1923

20 UNDERTAKER: J. C. Mitchell — ADDRESS: 1201 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may may be properly classified. Exact statement of CAUSE OF DEATH is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 129 D74058

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 W. Mulberry ST., 4 WARD)

2-FULL NAME Mary Alford Harper

(a) RESIDENCE NO. 117 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co. Maryland

PARENTS

10 NAME OF FATHER J. Browne Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary L. Moreton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. B. Harper

(Address) 345 N. Calvert St.

15 Filed MAR 22 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1922 to March 20, 1923, that I last saw her alive on March 20, 1923, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

To my knowledge 6 (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

do not know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. C. Kuser M. D.

, 19 (Address) Highland & Pitt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: 3/23, 1923

20 UNDERTAKER: Henry W. Mears & Son 805 — ADDRESS: N. Calvert

B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT MUST BE COMPLETE. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. It may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74059

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D74059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 Field St ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael McDonald

(a) RESIDENCE NO. 711 Field St. ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella Little

6 DATE OF BIRTH (month, day, and year) March 7-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 4 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westernport Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Isabella McDonald 711 Field St.

15 Filed Robert P. Harrison, Registrar

MAR 22 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 19 23 to Mar 20 1923

that I last saw h alive on Mar 20 1923

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH was as follows:

Pneumonia

(duration) yrs 20 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. A. Richardson M. D.

Mar 23 1923 (Address) 1120 N. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	March 23 1923
UNDERTAKER	ADDRESS
Horace H. Burgee	631 Hollins St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74060

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 N Montford ave. St., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan J Ellis

(a) RESIDENCE No. 1102 N Montford ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James N. Ellis

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER H. S. McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Amelia Guilford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Amelia E. Ellis

(Address) 1102 Montford ave

15 Robert P. Harrison, Registrar

MAR 22 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-10- ....., 1923 to 3-20 ....., 1923

that I last saw h[illegible] alive on 3-20 ....., 1923

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J Friedlander M. D.

3-22-23 (Address) 700 N Mass Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Mar 24 1923
20 UNDERTAKER	ADDRESS
Geo M. Fink & Son	811 W Lafayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be stated EXACTLY. PHYSICIANS should give information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D74061

D74061

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John H. Merryman

(a) Residence No. 1011 E. Biddle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word)
Male	White.	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Merryman

6-DATE OF BIRTH (month, day and year) ? ? 1882

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer) 686
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Merryman

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Katie Morsel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mercy Hospital Records

(Address)

MAR 23 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 19, 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923 to March 19, 1923

that I last saw him alive on March 19, 1923

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia,
Pleurisy with Effusion

(Duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Autopsy

What test confirmed diagnosis? Autopsy

(Signed) D. J. Sasaqua M. D.

19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Cathedral Cemetery	3/23/1923

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74062

Registered No. C.....

1-PLACE OF DEATH: Woodall's Shipyard,

City of BALTIMORE: (No. Foot of Woodall St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: William F. Hall.

64 --- 5 --- 6.

(Residence in Baltimore: No. 1233 Durst Al. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
White.	Male.	Widower.

6-DATE OF BIRTH. October 15, 1858.
(Month) (Day) (Year)

7-AGE. 64 yrs. 5 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Thomas Hall.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Margaret Fitzpatrick.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Hall. (son).

(Address) 1233 Durst Al.

Filed MAR 23 1923 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

March 22 19.. 3 (Address) 1014 St. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross [illegible] — DATE OF BURIAL: 3-23 1923

20-UNDERTAKER: Earle Hoke — ADDRESS: 115 E West St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Kuntz

D74063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74063

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 739 W. Fayette St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Kuntz

(Residence in Baltimore: No. 739 W. Fayette St.; 27 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Approximate AGE may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, ... Don't Know ..... 1..... (Month) (Day) (Year)

7-AGE, 29 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Dan Zaglosky

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Sarah Rhmovitz

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Balto

15. FILED MAR 23 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March (Month) 22 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy on~~ Inquiry.) thereon and from the evidence obtained by said ..... ~~Inquest, au-~~ ..... ~~topsy or~~ Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

..... (Duration) Don't Know yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D. (Coroner.)

3-23 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Fairview Baltimore DATE OF BURIAL, March 23, 1923

20-UNDERTAKER, Jos. Lewis ADDRESS 1439 E. Balto

Spec.—8-24-14—M. & T.—2000 Blks.

D74064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 129 D74064

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 5 South Fremont Avenue, ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Colombus W. Phillips,

(Residence in Baltimore: No. 5 South Fremont Avenue, St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male,	White,	Widowed

6-DATE OF BIRTH, ... May ..... 10th ....., 1867.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....55.... yrs. ...10... mos. ...10... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Marble cleaner,
(b) General nature of industry, business, or establishment in which employed (or employer)..... Public building

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Peter F. Phillips,

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Josephine Hughes,

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie C. Yingling, sister.

(Address) 5 South Fremont Avenue.

15- MAR 23 1923 ROBERT R. KRAUTER,
Filed....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March 21st ....., 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 20 1923, to March 21st 1923, that I saw him alive on March 20th 1923, and that death occurred, on the date stated above, at 6.45a.m.

The CAUSE OF DEATH* was as follows:

.....
...Chronic interstitial nephritis.....
.....
..... (Duration)...yrs.....mos.....ds.

CONTRIBUTORY..... inlefinite
(Secondary)
..... (Duration)...yrs.....mos.....ds.

(Signed) J. Frederick Hemple M.D.

Mar. 21., 1923 (Address) 3310 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, Mch. 23 1923

20-UNDERTAKER A. Jones ADDRESS 111 S. Gilmor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74065

CERTIFICATE OF DEATH.

90 D74065

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Carroll ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius J. Hurley.

(a) RESIDENCE No. 1112 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Delia Hurley.

6 DATE OF BIRTH (month, day, and year) May 21 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62.	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman.

(b) General nature of industry, business, or establishment in which employed (or employer) Monticello 162

(c) Name of employer Distillery

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Michael Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Moon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Delia Hurley. (Address) 1112 Carroll St

MAR 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 — 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1923, to Mar. 22, 1923,

that I last saw h alive on Mar 21, 1923,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Worley Hoag, M. D.

3/23. 1923 (Address) 724 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	3-24 1923
20 UNDERTAKER	ADDRESS
James Dignan & Son	Lloyd St Pace

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74066

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74066

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 S. Caloyton Road 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Hergenroeder

(a) RESIDENCE. No. 121 S. Caloyton Road WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sylvester Hergenroeder

6 DATE OF BIRTH (month, day, and year) March 16-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Henske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Regina Ryan

(Address) 121 Caloyton Road

15 MAR. 23 1923 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 5 - , 1923, to Mar 20 - , 1923, that I last saw h alive on Mar 20 - , 1923, and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insf.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw A Carter, M. D.

, 19 (Address) 2318 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar. 24 1923
20 UNDERTAKER	ADDRESS
George C. Schmal	1101 Bank St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74067 ✓ D74067

CERTIFICATE OF DEATH.

Registered No. C.....

D74067

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 S Monroe St., 20 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Stiebing

(Residence in Baltimore: No. 100 S Monroe St.; yrs., 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Feb (Month) 27 (Day) 1837 (Year)

7-AGE. 86 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. George Eichner

11-BIRTHPLACE OF FATHER. (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen F Stiebing

(Address) Bussonoue & Lee Funeral Directors

15- FILED MAR 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 21 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Sclerosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 6 yrs. mos. ds.

(Signed) James H McCandlish M. D. (Coroner.)

March 22, 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park DATE OF BURIAL. Mar. 23 1923

20-UNDERTAKER. George L. Schwab ADDRESS 2101 Eutaw Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74068

CERTIFICATE OF DEATH.

90 D74068

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Edmondson Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Amaral

(a) RESIDENCE. No. 1317 Edmondson Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonio Amaral

6 DATE OF BIRTH (month, day, and year) Feb 29-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77		20	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

11 Informant A. M. Amaral

(Address) 1317 Edmondson Av

15 Filed MAR 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 7, 1923, to Mch 21, 1923, that I last saw her alive on Mch 20, 1923, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) R. D. Wiat. , M. D.

, 19 (Address) 405 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Mch 24 1923
20 UNDERTAKER	ADDRESS
Chas E Franck	802 Madison Av

Duration should be carefully supplied. Avoid indefinite terms. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74069 ✓ D74069

D74069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4215 Liberty Hghts ST.: 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Samuel Michael Jr

(a) RESIDENCE. No. 4215 Liberty Hghts ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6/1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Hebert S. Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Dawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant H. S. Michael

(Address) 4215 Liberty Hgts Ave

15 MAR 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1923

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1923, to March 22, 1923, that I last saw h[illegible] live on March 22, 1923 and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) Probably yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Inter Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Murray, M. D.

, 19 (Address) 1221 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	March 24 1923

20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74070

D74070

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 John St ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Feighe Stewart

(a) RESIDENCE NO. 1311 John St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widowed.

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24 1836

7 AGE: Years 86; Months; Days; If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): U S A Co Md

12 MAIDEN NAME OF MOTHER: Mary Feighe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Lamar Stewart

(Address) 1311 John St

15 MAR 23 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1923 to Mch 22 1923.

that I last saw him alive on Mch 21 1923.

and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis —

(duration) 2 years mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas Maynard M. D.

Mch 23 1923 (Address) 132 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: March 24 1923

20 UNDERTAKER: A Meskimen & Son Co — ADDRESS: Orchard & Collins

N. B.—WRITE PLAINLY, with unfading ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74071 ✓ D74071

D74071

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

8 179

Registered No. C.....

City of BALTIMORE: (No. St. Joseph's Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth E. Pensel

(Residence in Baltimore: No. 1601 N. Bond St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
female	white	single

6-DATE OF BIRTH. March 17/1909 (Month) (Day) (Year)

7-AGE. 14 yrs. 0 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS:

10-NAME OF FATHER, John H. Pensel

11-BIRTHPLACE OF FATHER, (State or Country) Balto.MD.

12-MAIDEN NAME OF MOTHER, Catherine Hottes

13-BIRTHPLACE OF MOTHER, (State or Country) Balto.Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine H. P. Hasson(mother)

(Address) 1601 N. Bond St.

15- MAR 23 1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22/23 (Month) (Day) (Year) 192..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Legal

Toxemia due to 2nd& 3rd, burns over buttocks, back, chest, arms& legs (Duration) yrs. mos. ds.

(Clothing caught from gas heater in bath room Accident, occured on March 9/23 at 1601 N. Bond St.,

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Paul M. D. (Coroner.)

Mar 22 192 3 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore	Mch 24, 1923
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1739 Eager st

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74072

CERTIFICATE OF DEATH.

60-002 D74072

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE. (No. 4 Cooksie Court St. 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Smith

(Residence in Baltimore: No. 4 Cooksie Court St. (yrs., 10) mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Unknown ..... (Month) ..... (Day) ..... (Year)

7-AGE. About 43 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Va

PARENTS

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Cornish

(Address) 1129 Gough St

15-

MAR 23 1923 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 17 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by the Inquiry (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture & Hemorrhage from Cystic Goiter Unknown ds.
(Duration)

CONTRIBUTORY (Secondary) ..... Duration yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
Coroner

Mch 22 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Bal. R.R. Co.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Asbury

DATE OF BURIAL. March 23 1923

20-UNDERTAKER. John W. Henderson

ADDRESS 1502 E. Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74073

B74073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 W. Mulberry St. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Lynch.

(a) RESIDENCE NO. 914 Mulberry St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Nathaniel Lynch.

6 DATE OF BIRTH (month, day, and year) 4/12/1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster, Pa.

PARENTS

10 NAME OF FATHER John Ramsay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Virginia Deeken

(Address) 713-N. Fremont Ave

15 Filed MAR 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1923, to Mar. 21, 1923, that I last saw h alive on Mar. 20, 1923 and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 5 years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) G. Fedrick Ewell. M. D.

3/24/23 1923 (Address) 905 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	3/24/23

20 UNDERTAKER D. W. Jenkins. ADDRESS 1635 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. Every information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74074

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 D74074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Nellie Cawley

(a) RESIDENCE. No. 3014 O'Donnell ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Michael Cawley

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Jno. F. McCabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Nellie O. Cawley

(Address) 3014 O'Donnell St

15 Filed MAR 23 1923

16 ROBERT R. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1923

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1923, to March 22, 1923, that I last saw her alive on March 22, 1923, and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis.

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2-2-23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. V. Sayerbrick, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 3/26/1923

20 UNDERTAKER J. Kelly Stout

ADDRESS 318 Eighth Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D74075

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2812 Parkview Terrace ST., 9 WARD)

2-FULL NAME Alice Virginia Leonhardt Hershfeld.

(a) RESIDENCE NO. 2812 Parkview Terrace. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of Charles Price Hershfeld.

6 DATE OF BIRTH (month, day, and year) Jan, 5th, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work (Home)

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Leonhardt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Leonhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Miss Katherine Leonhardt.
(Address) 2812 Parkview Terrace.

15 MAR 23 1923 ROBERT R. KRAUTER, Registrar
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21st 1923

17

I HEREBY CERTIFY, That I attended deceased from March 10th, 1923, to March 21st, 1923, that I last saw her alive on March 21st, 1923, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma.

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? yes Date of Oct, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory.

(Signed) L. L. Gordy, M. D.

3-21, 1923 (Address) 4218 Harford Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Mar 24 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	126 E Monument St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74076

CERTIFICATE OF DEATH.

74-001 D74076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Queen

(a) RESIDENCE NO. Unknown (Usual place of abode) 1628 W. Lexington ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records.

(Address)

15 3 23 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 19 23

17

I HEREBY CERTIFY, That I attended deceased from December 7, 19 20, to March 20, 19 23,

that I last saw him alive on March 19, 19 23,

and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

3-20 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 23 1923
20 UNDERTAKER	ADDRESS
Brown & Pleasants Co	14 N

B—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

D74077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 188-003 D74077

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Franklin Hollenbery

(Residence in Baltimore: No. Reese Md. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write Word.)
male	white	Single

6-DATE OF BIRTH. 915
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
8 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: school boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Howard D. Hollenbery

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary E. Rinerman

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H.Bankard

(Address) Westminister Md.

15- Robert P. Harrison,

MAR 23 1923 192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Struck by auto-bus) Cerebral hemorrhage, fracture base of skull, fracture rt. femur & deep laceration lt. thigh. (skull decompression done at hospital.) (Inquest not yet held.)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) mos. ds.

(Signed) J S H Polar M. D.
(Coroner.)

3/23/23 192.... (Address) 58 E Northern

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Baust Cemetery Carroll Co	3/25 1923
20-UNDERTAKER.	ADDRESS
H Bankard & Son	Westminster

NOTICE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74078

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Old Orchard Road Ten Hills ST., 28 WARD)

New Edmondson City

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Allen Strauss

(a) RESIDENCE NO. Old Orchard Rd - Ten Hills ST., WARD

(Usual place of abode) New Edmondson City

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Strauss

6 DATE OF BIRTH (month, day, and year) March 12. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Strauss Town Pa

PARENTS

10 NAME OF FATHER Joel Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Emilie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Nellie Strauss (Address) Ten Hills

15 Robert P. Harrison, Registrar

MAR 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1- 1923, to March 23 1923, that I last saw him alive on March 23 1923, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular lesion

Nephritis acute -

High Blood Pressure

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Motion compensation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

3/23. 1923 (Address) 704 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL March 24, 1923.

20 UNDERTAKER C. W. Dill

ADDRESS 3129 Frank. Ave

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK. THIS ... should be stated EXACTLY. PHYSICIAN ... should be carefully supplied. AGE should ... may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74079 ✓ D74079

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Emmet Ave ST., Lauraville WARD 24)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M. Dietzel

(a) RESIDENCE NO. 202 Emmet Ave ST., Lauraville WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian A. Dietzel

6 DATE OF BIRTH (month, day, and year) Jan. 15 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pennsylvania

PARENTS

10 NAME OF FATHER Amos Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pennsylvania

12 MAIDEN NAME OF MOTHER Annie Rynel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pennsylvania

14 Informant Christian A. Dietzel

(Address) 202 Emmet Ave Lauraville

15 Filed Mar 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1923, to Mar 22, 1923, that I last saw him alive on Mar 21, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Endocarditis +

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic Arthritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Summers, M. D.

3-23, 1923 (Address) 4 206 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Mar 24 23
20 UNDERTAKER Fred Carson & Sons	ADDRESS Fullerton

B.—WHITE PAPER. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Schuckman) ✓

D74080 HEALTH DEPARTMENT—CITY OF BALTIMORE D74080

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2557 W Fayette ST., 20 WARD)

2-FULL NAME Charlotte Schuckman

(a) RESIDENCE NO. 2557 W Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NATIONALITY ~~Color~~ Schuckman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Fanny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Chas Schuckman

(Address) 2557 W Fayette

15 Filed MAR 29 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 22 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to March 22, 1923,

that I last saw her alive on March 22, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Nephritis Duration

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. Phillips, M. D.

March 23 1923 (Address) 1735 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 24 19
20 UNDERTAKER	ADDRESS
Geo W J Smith	[illegible]

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74081

D74081

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Hamburg ST., 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Royer.

(a) RESIDENCE No. 1211 Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 0 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry P. Royer

6 DATE OF BIRTH (month, day, and year) Feb 16 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Nelson J. Ryan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Denmark

12 MAIDEN NAME OF MOTHER Ann Christenson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Denmark

14 Informant Henry P. Royer.
(Address) 12 Dr. Sunderland Rd.

15 Filed MAR 23 1923 Robert P. Harrison., Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH 3

16 DATE OF DEATH (month, day, and year) Mar 22 1923

17

I HEREBY CERTIFY, That I attended deceased from March, 1923, to Mar 22, 1923, that I last saw h[illegible] alive on Mar 21, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Rheumatoid arthritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frederick Bruce M. D.

3/22 1923 (Address) 1 E Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	March 24 1923
UNDERTAKER	ADDRESS
Bollmann Son	Monument

N. B.—WHITE LABEL, which will be supplied. AGE should be carefully supplied. PHYSICIAN should state mation should be carefully supplied. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74082

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH 408 S. Vincent St.,

CITY OF BALTIMORE: (No. 408 S. Vincent St., ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Devine

(a) RESIDENCE. NO. 408 S. Vincent St., ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Marie Devine (NeeDavis)

6 DATE OF BIRTH (month, day, and year) April --1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	II		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Am. Paving Co.,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER James Devine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER --- Dockerty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Rose M. Devine (Address) 408 S. Vincent St.,

15 Robert F. Harrison, Registrar

MAR 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1923

17 I HEREBY CERTIFY That I attended deceased from Jan 1923 to March 21 1923

that I last saw him alive on March 20 1923

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH was as follows: Bright's Disease

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) R. F. Harrison, M. D.

(Address) Catonsville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/24 1923

20 UNDERTAKER, Harry F. Weyler

ADDRESS 1531 W. Fayette St.

Information should be carefully supplied. AGE should be stated EXACTLY. Fractions of a year may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74083

CERTIFICATE OF DEATH.

161-001 D74083

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3403 Bonday ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Organ

(a) RESIDENCE. No. 3403 Bonday ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 20-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1923	Mar 20	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 3403 Bonday st

PARENTS

10 NAME OF FATHER Levi Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Organ

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Danville Va.

14 Informant Elizabeth Organ
(Address) 3403 - Bonday st.

15 Filed MAR 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1923, to Mar 23, 1923, that I last saw h[illegible] alive on Mar 22, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Louis A. Johnson M. D.

, 19 (Address) 211-E-20th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Mar 24 1923
20 UNDERTAKER	ADDRESS
Brown & Eichard	[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

074084 074084

CERTIFICATE OF DEATH.

90

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 N. Washington WARD)

2-FULL NAME Augusta Albrecht

(a) RESIDENCE NO. 1710 N. Washington ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? 62 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Joseph A. Albrecht.

6 DATE OF BIRTH (month, day, and year) May 6 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	67	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Joseph A. Albrecht (Address) 1710 N. Washington St

15 Filed Robert P. Harrison Registrar

24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1922 to Mar 22 1923, that I last saw her alive on Mar 22, 1923, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis - Hemiplegia

(duration) 1 yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. 12 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) M. Thomas, M. D.

Mar 24, 1923 (Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Mar 26 1923
20 UNDERTAKER	ADDRESS
Henry Hoech Son	1301 E. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS' should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D74085 HEALTH DEPARTMENT—CITY OF BALTIMORE D74085

CERTIFICATE OF DEATH. 4 185 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Clinton Street St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Almet Van Valkenburgh

(Residence in Baltimore: No. 753 W. Lexington Street St.; yrs., 5.) ~~mos.~~ ~~ds.~~)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Not Known ..... 1..... (Month) (Day) (Year)

7-AGE: 51 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer): Stevedore

9-BIRTHPLACE, (State or Country): New York State

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER, (State or Country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER, (State or Country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Percy W. Decker

(Address) Catskill N.Y.

15- Filed MAR 24 1923 192.... Robert P. Harrison, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March (Month) 22 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain

died at once (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fractured Skull

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hyp. B. Horton M. D. (Coroner)

Mch 23rd 1923 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Coxsackie, Green Co. N.Y. DATE OF BURIAL: March 24 1923

20-UNDERTAKER: John F. Denny ADDRESS: 715 Light St

8.—Every item of information should be carefully supplied. Exact statement of OCCUP... is very important. See instructions on back of certificate. state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74086

CERTIFICATE OF DEATH.

100-80

D74086

1-PLACE OF DEATH 922 Riggaith St

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Uhlelbach

(a) RESIDENCE NO. 922 Riggaith ST., 10 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John Uhlelbach

6 DATE OF BIRTH (month, day, and year) March 24, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Roehler (Address) 922 Riggaith St.

15 Filed MAR 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Febr. 25, 1923 to March 20, 1923, that I last saw h[illegible] alive on March 20, 1923 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) E. J. Lobel, M. D.

, 19 (Address) 1001 Riggaith St.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	3/24/23
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Stratford Ave

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74087

CERTIFICATE OF DEATH.

60-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel Hanna

(a) Residence No. 100 Susquehanna Ave Towson Md. St., ... Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 9 1889.

7-AGE, 33 yrs. 8 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Hugh B Hanna

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Letitia Sweeney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Penna

14-(Informant) Mercy Hospital Records

(Address).....

MAR 23 1923 Robert P. Harrison, Registrar.

MAR 24 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23 '23

17- I HEREBY CERTIFY, That I attended deceased from March 9 19 23 to March 23 19 23

that I last saw h. alive on March 23 19 23

and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows: †

Hyperthyroidism

Ebalmic goiter

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage

Post Oper. (Duration) ..... yrs. ..... mos. 8 ds.

18-Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? Yes Date of 3-14-23 3-21-23

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Oper findings

(Signed) J. Mercy Hospital M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery — DATE OF BURIAL, 31 24 19 23

20-UNDERTAKER. Henry W. Mears & Son — ADDRESS 805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE is very important and should be filled. Exact statement of OCCUPATION is very important. CAUSE OF DEATH should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74088

CERTIFICATE OF DEATH.

91-D74088

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 N. Baltimore St. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Saint Walbert (Josephine Scurry)

(a) RESIDENCE. No. 2000 N. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? 44 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 16-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mother M. Benedict, 2000 N. Baltimore St.

15 Filed MAR 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1923, to Mar 23, 1923, that I last saw h[illegible] alive on " ", 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of "

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. F. Cashman, M. D.

3/23, 1923 (Address) 24 N. Duncan Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Mar. 26 1923
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E. Eager St.

NB.—WHITE PAPER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and UNDERTAKER'S information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74089

CERTIFICATE OF DEATH.

74001 D74089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2420 N. Charles ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Hall Darnall

(a) RESIDENCE NO. 2420 N. Charles ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Eleanor Carroll Darnall

6 DATE OF BIRTH (month, day, and year): Oct 1 - 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard B. Darnall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eleanor Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): R. Bennett Darnall Fidelity Building

15 Robert P. Harrison, Registrar

, 19 Burial Permit Clerk

APR 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 23, 1923, that I last saw him alive on March 23, 1923, and that death occurred, on the date stated above, at 7½ P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas O'Donovan, M. D.

March, 1923 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemetery — DATE OF BURIAL: 3/26/1923

UNDERTAKER: Chas. E. Evans & Son — ADDRESS: 11 S. Smith Royal Ave

INSTRUCTIONS: Every question should be stated EXACTLY. PHYSICIAN should state information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74090 1

CERTIFICATE OF DEATH.

161-001 D74090

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1707 Cole ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Lab

(a) RESIDENCE NO. 1707 Cole ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 13 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John R. Lab

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Clara Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) John R. Lab 1707 Cole st

15 Filed . 19 Registrar

Burial Permit Clerk.

MAR 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to March 24, 1923, that I last saw he alive on March 23, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Woolman M. D.

1923 (Address) 728 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters

DATE OF BURIAL March 24 1923

20 UNDERTAKER George A. Farley

ADDRESS Fulton Station

AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE mation should be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74091

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74091

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3910 Oakford Avenue ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Virginia Stansbury

(a) RESIDENCE NO. 3910 Oakford Avenue ST., 15 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 85 yrs. 3 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Samuel Stansbury

6 DATE OF BIRTH (month, day, and year) Nov-27-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) New Winsor
(State or country) Caroll Co Maryland

PARENTS

10 NAME OF FATHER William Pole

11 BIRTHPLACE OF FATHER (city or town) New Winsor
(State or country) Caroll Co Maryland

12 MAIDEN NAME OF MOTHER Emily Stir

13 BIRTHPLACE OF MOTHER (city or town) New Winsor
(State or country) Caroll Co Maryland

14 Informant Mr William L Stansbury (son)
(Address) 3910 Oakford Avenue

15 Robert P. Harrison, ... 19 .....
Registrar

Burial Permit Clerk

MAR 24 192

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1923, to March 22, 1923.

that I last saw her alive on March 21, 1923,

and that death occurred, on the date stated above, at 9.40A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Senile Heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion Lungs
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pole, M. D.

, 1923 (Address) 2032 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Mar-24-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 103 W. NORTH AVE.

I. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied.

Spec–12-23-21–E.B.R.S.–400 Blks.

D74092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74092

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 217 Club Road St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah A. Littig-Shaffer Ramsay

(a) Residence No. 217 Club Road St., 27 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 94 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? 94 yrs. 3 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Glendy Ramsay

6-DATE OF BIRTH (month, day and year) Dec-20-1828

7-AGE.	If LESS than 1 day.
94 yrs. 3 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer..... None

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Frederick Littig Shaffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Hannah W. Pitt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Miss. Nannie Ramsay (daughter)

(Address) 217 Club Road

15- Filed ..... 192.. Robert P. Harrison, Registrar.

MAR 24 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 22-23

17- I HEREBY CERTIFY, That I attended deceased from March 19 23 to March 22 19 23

that I last saw h. alive on March 21 19 23

and that death occurred, on the date stated above, at 10-30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (Fracture of Femur)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Epistaxis Shock

(Duration) ..... yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) C B Grandlup M. D

Mar 23 1923 (Address) 26 W Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Greenmount Cemetery	Mar-24-23 19....
20-UNDERTAKER.	**ADDRESS**
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	108 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Age should be carefully supplied. AGE should be stated
instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Curtis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74093

CERTIFICATE OF DEATH.

129

D74093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020½ Carey, ST., 16 WARD)

2-FULL NAME Mary Curtis

(a) RESIDENCE NO. 1020½ Carey St, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of James Curtis

6 DATE OF BIRTH (month, day, and year) Dec 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	53			

8 OCCUPATION OF DECEASED at home,

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress, 70

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Thos Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Alice Smith

(Address) 1020½ Carey St

15 Filed ....., 19.... Registrar Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to March 22 1923, that I last saw h[illegible] alive on March, 1923, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 3 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumin in urine

(Signed) John C Stewart M. D.

, 19 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	March 26th 1923
20 UNDERTAKER	ADDRESS
Samuel Wright	1364 Mary

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MAR 24 1923

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74094

CERTIFICATE OF DEATH.

Y01-001 D74094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2701 Riggs ave, St.; 16 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marshall E. Hirsfield

(Residence in Baltimore: No. 2701 Riggs ave St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 4 (Day), 1889 (Year)

7-AGE, 33 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Commission Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 445

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm. D. Hirsfield

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary L. Linthicum

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lorrin H. Bowers

(Address) 2701 Riggs Ave.

15-

Filed ....., 191.... Robert E. Harrison, Registrar.

JUN 24 1923

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6th 1923, to June 22nd 1923, that I saw h-im alive on June 22nd 1923, and that death occurred, on the date stated above, at 12-10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Colon Carcinoma

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Greene M. D.

June 22nd, 1923. (Address) 1624 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. ..... mos. ..... ds. In the State 32 yrs. 9 mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 2701 Riggs ave

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cy DATE OF BURIAL, March 26 1923

20-UNDERTAKER Jos Jacobsen Son ADDRESS 217 S. Paca

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74095

CERTIFICATE OF DEATH.

11-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 N. Streeper ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian M. Gunzelman

(a) RESIDENCE. NO. 528 N. Streeper ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 12, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George C. Gunzelman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Prechtel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant George C. Gunzelman
(Address) 528 N. Streeper

R 24 1923 [illegible] 19

[illegible] Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-19, 1923, to 3-24, 1923
that I last saw her alive on 3-21, 1923
and that death occurred, on the date stated above, at 10 m.
The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Bronchio-Pneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Autopsy
(Signed) Fred Gunzelman, M. D.
3-28, 19 (Address) 800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 24 1923

20 UNDERTAKER Hans H. Weitzel
ADDRESS 1531 W. Lombard St.

mation should be carefully supplied. AGE should be stated EXACTLY. If UNKNOWN, approximate may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74096

HEALTH DEPARTMENT--CITY OF BALTIMORE

D74096

CERTIFICATE OF DEATH.

11-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2331 E. Chase ST., 8 WARD)

2-FULL NAME Frank C. May

(a) RESIDENCE No. 2331 E Chase ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Casper J. May

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Lindenstruth

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Casper J. May
(Address) 2331 E Chase St

15 Filed ..... 19 .....
Registrar

R 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1923

17

I HEREBY CERTIFY, That I attended deceased from 3-1-, 1923 to 3-22, 1923

that I last saw h[illegible] alive on 3-22, 1923

and that death occurred, on the date stated above, at 12 [illegible] P. m.

The CAUSE OF DEATH* was as follows:

acute Tonsilitis, - La Grippe

(duration) yrs. ..... mos. 17 da.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. ..... mos. 7 da.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) [illegible] M. D.

3-23, 1923 (Address) 600 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL 3/24 1923

20 UNDERTAKER Philip Henry

ADDRESS 2016 Adam

N. B.—WRITE PLAINLY, WITH CARE AND NEATNESS. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3807 Woodbine St., 27 Ward)

Registered No. 275-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Hill Mullins

(a) Residence No. 3807 Woodbine St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie S. Mullins.

6-DATE OF BIRTH (month, day and year) Dec. 6, 1861

7-AGE, 61 yrs. 3 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Samuel J.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown.

14- (Informant) Thomas M. Rives.

(Address) 3807 Woodbine Ave.

15- [illegible] Robert P. HARTSOCK, Registrar.

MAR 24 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 21-1923

17- I HEREBY CERTIFY, That I attended deceased from Mar. 11, 1923, to Mar. 21, 1923

that I last saw h[illegible] alive on Mar. 21, 1923

and that death occurred, on the date stated above, at 8.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral

Arterio-Sclerosis

(Hemiplegia)

(Duration) 6 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Uremia (Toxemia)

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Wood, M. D.

, 19 (Address) 700 N. Howard St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Floyd Va

DATE OF BURIAL, ..., 1923

20-UNDERTAKER, John O. Mitchell

ADDRESS 1201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74098

CERTIFICATE OF DEATH.

49 D74098

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2623 St. Paul ST., 12 WARD)

2-FULL NAME George Edgar Caulk

(a) RESIDENCE NO. 2623 St. Paul ST., 12 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2 1873

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	49	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

009

9 BIRTHPLACE (city or town) Annapolis
(State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Caulk

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Brown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Frederick Co., Maryland

14 Informant Mrs. Bessie Caulk
(Address) 2623 St. Paul St.

15 ..... 19 ..... Registrar Robert E. Harrison
Burial Permit Clerk.

MAR 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1923, to March 23, 1923, that I last saw him alive on March 23, 1923, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma, Right Brachial Arch

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) —
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan. 9th 1923

Was there an autopsy? No

What test confirmed diagnosis? Macro + Microscopic

(Signed) C. Hunt Stevenson Jr. M. D.

, 19 (Address) 2529 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Anne's Cemetery Annapolis Md	Mar 25 1923
20 UNDERTAKER	ADDRESS
Stewart & Warren Company	1858 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74099

CERTIFICATE OF DEATH.

99-001

D74099

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1002 Woodyear ST., 16 WARD)

2-FULL NAME Harriet O Mills

(a) RESIDENCE No. 1002 Woodyear ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Cal | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): mar.

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): John O Mills

6 DATE OF BIRTH (month, day, and year): [illegible] 1854

7 AGE: 65 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Hubert F Mills

(Address): 1002 Woodyear St.

15 Filed 3 24 1923 19... Robt. F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-20 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-19-23, 19..., to 3-20-23, 19...

that I last saw h... alive on ... 19...

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows: 1. acute Pneumonitis

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary): senility, debility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ...

Was there an autopsy? "

What test confirmed diagnosis?

(Signed) F McCandless, M. D.

3-21-1923 (Address) 1624 O'Hill ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] | DATE OF BURIAL: Mar 24 1923

20 UNDERTAKER: Chas A Mills & Woman. | ADDRESS 1213

NOTE.—WRITE PLAINLY, WITH PENCIL OR INK. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74100 D74100

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 N. Carey ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otis Ector May.

(a) RESIDENCE. No. 1501 N. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Selma Mays

6 DATE OF BIRTH (month, day, and year) Aug 16. 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter & Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer),

(c) Name of employer Swift Bros. & Self. 50

9 BIRTHPLACE (city or town) (State or country) Griffin Ga.

PARENTS

10 NAME OF FATHER Mac May

11 BIRTHPLACE OF FATHER (city or town) (State or country) Monroe Co. Ga.

12 MAIDEN NAME OF MOTHER Annie Gaspray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Monroe Co. Ga.

14 Informant Annie May
(Address) 1501 N. Carey St

15 Filed MAR 24 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to March 22, 1923, that I last saw him alive on March 22, 1923, and that death occurred, on the date stated above, at 4 1/0 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical-Sputum

(Signed) William H Wright, M. D.

Mar 23, 1923 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar. 25 1923
20 UNDERTAKER James H. Dennis	ADDRESS 1303 Pres Ave

Robert P. Bertram, Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74101

D74101

CERTIFICATE OF DEATH.

REGISTERED NO. C 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1010 E. Monument ST.; 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Cimino

(Residence in Baltimore: No. 1010 E. Monument St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Feb 21 (Month) (Day), 1923 (Year)

7-AGE, ...yrs. 1 mos. 2 ds. | If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Charles Cimino

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosa Zaccari

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Cimino

(Address) 1010 E. Monument St

15-

Mar 24 1923, 191.... Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23 (Month) (Day), 1923 (Year)

I HEREBY CERTIFY, That I attended deceased from March 11 1923, to March 23 1923, that I saw h me alive on March 23 1923, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Cholera infantum

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. D. Testa M. D.

...., 191... (Address) 210 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, St Vincents Cem | DATE OF BURIAL, 3/24, 1923

20-UNDERTAKER George J. Ruth | ADDRESS 1735 Hanford Ave

IMPORTANT. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Topper)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74102

CERTIFICATE OF DEATH.

131 D74102

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1720 N Fulton ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Allen Topper

(a) RESIDENCE. No. 1720 N Fulton ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Susan Topper

6 DATE OF BIRTH (month, day, and year) 1893.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	-	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plaster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fredericksburg Co. Md.

PARENTS

10 NAME OF FATHER John F. Topper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Virginia Worthen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredericksburg Va Md

14 Informant John F. Topper

(Address) 1642 N Fulton ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

APR 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb-23 1923, to March 22, 1923,

that I last saw h[illegible] alive on March 22, 1923,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hydrothorax

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Conclusions

(Signed) [illegible] Fulton, M. D.

. 19 (Address) 1012 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	March 26 23
20 UNDERTAKER	ADDRESS
Martin Kenyon Sons	1822 W North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.74103 HEALTH DEPARTMENT—CITY OF BALTIMORE D.74103

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 W. Pratt ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse B Morris

(a) RESIDENCE. NO. 1413 W. Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec-8-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry L. Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Bessie Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry L. Morris (Address) 1413 W. Pratt St.

15 Filed 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 22, 1923, that I last saw him alive on March 22, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) H. W. Jones - W. H. Skilling M. D.

3-24, 1923 (Address) 1120 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 26 1923
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74104 ✓ D74104

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 904 S. Carey. (ST.) (WARD) 24 N W

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Gunn.

(a) RESIDENCE NO. 904 S. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female. 4 COLOR OR RACE: White. 5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard Gunn.

6 DATE OF BIRTH (month, day, and year): not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: not known.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Annie M Gunn.

(Address): 904 S Carey.

MAR 24 1923 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1923, to March 23, 1923.

that I last saw her alive on March 23, 1923.

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 2 yrs. — mos. — da.

CONTRIBUTORY (Secondary): Old age.

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Analysis.

(Signed) Thos Boston, M. D.

3/23, 1923 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral: Cem.	3-26, 1923
20 UNDERTAKER: James Dignan & Son	ADDRESS: 1005 Race St

N. B.—Blanks must be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74105

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-002 D74105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1211 Hull St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Doris Loose

(a) Residence No. 1211 Hull St., 24 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 25 1922

7-AGE ... yrs. 7 mos. 25 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Fritz Loose

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Carrie Stumpf

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto md.

14- (Informant) Fritz Loose

(Address) 1211 Hull St.

15- Robert P. Harrison, M.D.
Registrar.

MAR 24 1923

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 22, 23

17- I HEREBY CERTIFY, That I attended deceased from Jan. 22 1923 to March 22 1923.

that I last saw h[illegible] alive on March 21 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Uncomplicated)

(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY
(Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Stevens M. D

3/23 1923 (Address) 2878 Hartford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk. DATE OF BURIAL: 3/24 1923

20-UNDERTAKER: J. J. Fahey Sons ADDRESS: 1318 Light St.

Unless classified. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. Entries should be carefully supplied. Avoid ambiguous or indefinite instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74106

CERTIFICATE OF DEATH.

11-60 D74106

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 W. Lanvale ST. 13 WARD)

2-FULL NAME Joseph Shutterworth Allender

(a) RESIDENCE NO. 2810 Parkwood Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth R. Allender

6 DATE OF BIRTH (month, day, and year) Jan 13 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer W. Va

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER James Allender

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mary Shutterworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Elizabeth R. Allender
(Address) 2810 Parkwood Ave

15 Filed MAR 24 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 22, 1923, that I last saw him alive on March 22, 1923, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Grip

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs and symptoms

(Signed) J. F. Thennell, M. D.

Mar 23 1923 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Mar 24 1923

20 UNDERTAKER Wm Hickney & Sons

ADDRESS North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74107

CERTIFICATE OF DEATH.

159-001 D74107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 new Belair Rd ST., Brehms Lane WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Hummel

(a) RESIDENCE NO. Brehms Lane WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 19 1922

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER John D. Hummel

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Zenora E. Ebbutt

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant John D. Hummel (Address) Brehms Lane

15 Filed Mar 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 22 1923

17 I HEREBY CERTIFY, That I attended deceased from birth, 19 23, to Mch 22, 19 23, that I last saw him alive on Mch 22, 1923, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

Malnutrition

(Duration) birth mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? —

(Signed) Egustan Dill M. D.

3/23 1923 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Mar 24 1923
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 24 1923

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74108

CERTIFICATE OF DEATH.

101-001 D74108

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4206 Wrenwood Ave St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Greve

(a) Residence No. 4206 Wrenwood Ave St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 4/03 Mch 23/23

7-AGE. 20 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Telephone Operator

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Louis Greve

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Eliz Bangheart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

11- (Informant) Louis Greve

(Address) 4206 Wrenwood Ave

24 1923 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mch 23/23

17- I HEREBY CERTIFY, That I attended deceased from Mch 17, 1923 to Mch 23 1923, that I last saw h[illegible] alive on Mch 23, 1923 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H W Wheaton M. D

, 19 (Address) 4739 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Park Wood Cem

DATE OF BURIAL. 3/26 1923

20-UNDERTAKER. ROBERT BROOKS & SON

ADDRESS Eutaw Hollins sts

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

(over) Burial Permit Clerk?

(over)

Spec.—1-10-21—M&T—1500 Blks.

D74109

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-00 D74109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene. ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Martin

(a) RESIDENCE NO. 1401 Division St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 3/12/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Martin

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Annie Trailer

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Margaret Martin
(Address) 1401 Division St

15 Filed ..... 19 .....

Robert F. Harrison,
Burial Permit Clerk. Registrar

R 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 1923.

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1923, to 3/21, 1923, that I last saw h[illegible] alive on 3/21, 1923, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

..... (duration) yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Outside

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Iron Mirdam, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral bens	3/24 1923
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74110 D74110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 E. Randall St. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine McCormick

(a) RESIDENCE. NO. 416 E. Randall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. McCormick

6 DATE OF BIRTH (month, day, and year) Sept 29/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Deranny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Honora Stanton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mary O'Donnell 416 E Randall St

15 Filed APR 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 23 March 1923

17

I HEREBY CERTIFY, That I attended deceased from 19th March, 1923, to 23 March, 1923, that I last saw her alive on 22 March, 1923, and that death occurred, on the date stated above, at 7:20 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Thomas W Bryan, M. D.

, 19 (Address) 749 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cathedral	Mar 26 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU TION is very important. See instructions on back of certificates.

D74111 HEALTH DEPARTMENT—CITY OF BALTIMORE D74111

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 647 W Pratt St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Geo W. Leimbach

(Residence in Baltimore: No. 647 W Pratt, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 4 (Day) 1865 (Year)

7-AGE, 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Undertaker
(b) General nature of industry, business, or establishment in which employed (or employer). Own

9-BIRTHPLACE, (State or Country). B. City

PARENTS.

10-NAME OF FATHER. Geo Leimbach.

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Susan Dill

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H Leimbach

(Address) 525 Lyndhurst St

15-

MAR 24 1923

Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 23 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ Inquest, and thereon and from the evidence obtained by said Inquest, and find that said deceased came to his death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. mos. ds.

(Signed) H. K. Gruwell M. D. (Coroner.)

3-24 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, 3/27/23, 19

20-UNDERTAKER, Geo Leimbach & Son — ADDRESS 647 W Pratt St

M.C.—Every item of information should be carefully supplied. See that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74112 D74112 103

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Carroll St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Keiser

(Residence in Baltimore: No. 1215 Carroll St.; 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widowed

6-DATE OF BIRTH. Aug 11, 1843 (Month) (Day) (Year)

7-AGE. 79 yrs. 7 mos. 12 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. HW
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Keiser

(Address) 1175 Cleveland

15- Filed ....., 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

MAR 24 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 3, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1923 to March 3 1923, that I saw her alive on March 2 1923 and that death occurred, on the date stated above, at 7:50 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John G. Sollmann M. D.

3/24/23 1911 (Address) 1111 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park | DATE OF BURIAL. 3/24/23, 191...

20-UNDERTAKER Geo Leimbach & Son | ADDRESS 647 W Pratt St.

NOTE—Every item of information should be carefully supplied. Age should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74/10574113

CERTIFICATE OF DEATH.

XII-102 10574113

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Maryland General Hospital (ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luke A. Stafford

(a) RESIDENCE NO. Eldridge Md. ST., WARD Eldridge Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
32				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Leo W Stafford

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Nettie Turlington

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John L Stafford

(Address) Eldridge Md

15 FILED MAR 25 1923 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 24, 1923, that I last saw h[illegible] alive on March 24, 1923, and that death occurred, on the date stated above, at 3.10 p. m.

The CAUSE OF DEATH* was as follows:

1. Acute Nephritis

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Acute Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va — DATE OF BURIAL March 24 1923

20 UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16 2000 D74114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74114

CERTIFICATE OF DEATH.

X 70

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. (NO.....) ST., 7 WARD)

2-FULL NAME Julius P. Richardson

(a) RESIDENCE NO. 618 McMahon ST., ... WARD Durham, S.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 22 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 12 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-keeper

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) N.C.
(State or country)

PARENTS

10 NAME OF FATHER Clifton

11 BIRTHPLACE OF FATHER (city or town) N C
(State or country)

12 MAIDEN NAME OF MOTHER Anne

13 BIRTHPLACE OF MOTHER (city or town) N.C.
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Durham

15 Filed MAR 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 2-24, 1923, to March 24, 1923, that I last saw him alive on March 24th, 1923, and that death occurred, on the date stated above, at 2 05 P. m.

The CAUSE OF DEATH* was as follows:

Brain abscess

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? S Carolina

Did an operation precede death? Yes Date of March 22-1923

Was there an autopsy? No

What test confirmed diagnosis? Operation & Culture

(Signed) Warfield M Dixon, M. D.

, 19 (Address) 1 Hilt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Durham, S. C. — DATE OF BURIAL Mar 25 1923

20 UNDERTAKER W E Hughes — ADDRESS 401 W Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74115

CERTIFICATE OF DEATH.

90 D74115

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 N. Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Hudgins

(a) RESIDENCE. NO. 307 N. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or ~~WIFE of~~) Bettie Hudgins

6 DATE OF BIRTH (month, day, and year) Sept 27 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Merchant)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middlesex Co. Va.

PARENTS

10 NAME OF FATHER Wm Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mildred ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs. Clara S. Chowning 307 N. Carey St.

15 Filed MAR 25 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 22nd 1923, to March 22, 1923, that I last saw him alive on March 20, 1923, and that death occurred, on the date stated above, at 6.40 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. two months ds.

CONTRIBUTORY (Secondary) Myocarditis & Arterio sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) C. H. H. Clift, M. D.

3/22, 1923 (Address) 312 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
White Marsh, Merry Point Va.	Mar 24 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bal. St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74116 — 129 — D74116

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4207 Euclid Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Bilson

(a) RESIDENCE No. 4207 Euclid Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. ✓ mos. 24 ds. How long in U. S., if of foreign birth? 71 yrs. ✓ mos. 2(ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lucy J Bilson

6 DATE OF BIRTH (month, day, and year) Sept 28-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	71	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Capt Fire Dept

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City Fire Dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew J. Bilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lucy Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lucy J. Bilson (Address) 4207 Euclid Ave Baltimore Md

15 MAR 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1923 to March 24, 1923, that I last saw him alive on March 23 1923, and that death occurred, on the date stated above, at 1 00 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. 7+ mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) ~~H.W. Jones~~ W. K. Skilling M. D.

3-24 1923 (Address) 1120 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Mar 27 1923

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1944 W. Northam

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74117

CERTIFICATE OF DEATH.

90 D 74117

1-PLACE OF DEATH

Registered No. D74117

City of BALTIMORE: (No. 1320 E. Monument St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hayes

(Residence in Baltimore: No. 1320 E. Monument St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (write word.)
male	col.	married

6-DATE OF BIRTH. ..... unknown ....., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
48 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: stevedore
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Dover Del.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) SODONIE HAYES

(Address) 1320 E. Monument

MAR 25 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22/23 192 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insuffiency

(Treated By Dr. Carghill for cardiec asthma 2 mons. ago (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

3/23/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oakley — DATE OF BURIAL. March 25 1923

20-UNDERTAKER. John W Henderson — ADDRESS 1301 E monument

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21

D74118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 S. Chester ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franciszka Tucholska

(a) RESIDENCE NO. 437 S. Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wojciech Gorny.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Veronica Kowalska

(Address) 437 S. Chester St.

15 MAR 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 18, 1923, to Mar 25, 1923, that I last saw h-e alive on Mar 25, 1923 and that death occurred, on the date stated above, at 1.30 9 m.

The CAUSE OF DEATH* was as follows:

Fatal Dysentery

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Mar 25, 1923 (Address) 1314 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Mar 26 1923

20 UNDERTAKER Wm Hallowell

ADDRESS 618 Eastern

NOTICE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Douglass
830 W North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74119

CERTIFICATE OF DEATH.

74-001 D74119

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 20 East Lafayette St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Gertrude Mc Dougall

(a) Residence No. 20 East Lafayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-If Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas. Mc Dougall

6-DATE OF BIRTH (month, day and year): Aug 8-1854

7-AGE: 68 yrs. 7 mos. 15 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.
10-NAME OF FATHER: ? Collins
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-INFORMANT: Jas Mc Dougall
(Address): 20 E. Lafayette

15-FILED: MAR 25 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 23-1923

17- I HEREBY CERTIFY, That I attended deceased from March 16th, 1923 to March 23rd, 1923, that I last saw her alive on March 23rd, 1923 and that death occurred, on the date stated above, at 7.00 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(Duration) 6 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? Balto.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglass, M. D.
Md. 24 1923 (Address) 830 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn | DATE OF BURIAL: 3/26 1923

20-UNDERTAKER: Wm Cook | ADDRESS: 502 E Nor

Should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. In plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74120 D74120

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 N. Amity St. 18 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Coates

(a) RESIDENCE. No. 6 N. Amity St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Coates

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 42 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Stevedore

(c) Name of employer: Longshoremens Assn

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriet Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mary Coates 6 N Amity St

15 MAR 25 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22/1923

17 I HEREBY CERTIFY, That I attended deceased from 3/18/1923 to 3/22/1923, that I last saw h alive on 3/21/1923, and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia 8 ds.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

Signed) J. Sumpter Boyle M. D.

3/23/1923 (Address) 908 Asharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 25 1923
20-UNDERTAKER	ADDRESS
Brown & Eveland	Schroder

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74121

CERTIFICATE OF DEATH.

48 D74121

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Paul Apts ST., 11 WARD)

2-FULL NAME Theodosia Hardy Goodwin

(a) RESIDENCE NO. St Paul Apartments ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND (or) WIFE of Maj. C. L. Goodwin

6 DATE OF BIRTH (month, day, and year) May 4 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Charles Wesley Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Rebecca Purse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant Percy H Goodwin
(Address) Catonsville

15 MAR 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1922, to March 23rd, 1923, that I last saw h.2 alive on March 23rd, 1923, and that death occurred, on the date stated above, at 8.50 P m.

The CAUSE OF DEATH* was as follows:

Durcoma - Axilla - Skin -

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Haemorrhage from Gyneth

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. h. McGowan Asst. M. D.

3.24. 1923 (Address) 1515 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Mar 25 1923

20 UNDERTAKER: Henry W Jenkins Sons Co — ADDRESS: McCulloh & Orchard Sts

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D74122

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 S Chapel ST., 7 WARD)

2-FULL NAME Josephine Andrzychowski

(a) RESIDENCE NO. 527 S Chapel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Andrzychowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Stella Juliszewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Joseph Andrzychowski
(Address) 527 S Chapel St

15 MAR 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-19 1923 to March 24 1923.
that I last saw her alive on March 23 1923
and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar (5 mo)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Congenital Heart

(duration) ..... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes What test confirmed diagnosis? Findings

[illegible] 1923 (Address) 700 N Patterson Park Ave M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	March 25 1923
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

NAME should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-00 | ✓ 74123

D74123

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3209 Esther Place St., No WARD)

2-FULL NAME Mary E. Montgomery

(a) RESIDENCE NO. 3209 Esther Place St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, (HUSBAND) of (or) WIFE of: late Geo. W. Montgomery

6 DATE OF BIRTH (month, day, and year): June 27-45

7 AGE — Years: 77 — Months: 8 — Days: 24 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Geo. P. Montgomery
(Address) 3209 Esther Pl.

15 Filed MAR 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/23 1923

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1923, to March 23 1923, that I last saw her alive on March 23, 1923, and that death occurred, on the date stated above, at 9-15 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John L. Crutcher M. D.

March 24 1923 (Address) 35 W Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fork Md — DATE OF BURIAL: 3/26 1923

20 UNDERTAKER: Philip Henrig — ADDRESS 2016 Orleans

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74124 ✓ 74124

CERTIFICATE OF DEATH.

31 D74124

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 4008 Falls Road (St.; 13 Ward) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Elmer Hook

(Residence in Baltimore: No. 4008 Falls Road St.; 27 yrs., 3 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 21 1895
(Month) (Day) (Year)

7-AGE, 27 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer) Chas. E. Baer

9-BIRTHPLACE, (State or Country), Balto City Md

PARENTS.

10-NAME OF FATHER, Oscar Hook

11-BIRTHPLACE OF FATHER (State or Country), Balto City Md

12-MAIDEN NAME OF MOTHER Catherine Welsh

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Irene Hook

(Address) 4008 Falls Rd.

15- Filed MAR 25 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1922, to March 23 1923, that I saw h[e] alive on March 23 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Malnutrition - Exhaustion

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) ....yrs. 4 mos. ....ds.

(Signed) Aaron Kelly M. D.

3/27, 1923. Address 3705 Falls Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Druid Ridge — DATE OF BURIAL, Mar. 26, 1923

20-UNDERTAKER D. S. Marshall 3539 — ADDRESS Falls Rd.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Olivia H. Myles

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74125 CERTIFICATE OF DEATH. D74125

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 855 Harlem Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia H Myles

(a) RESIDENCE. NO. 855 Harlem Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Calvert Co, Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Thomas Nally

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Sarah A. Justice

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Miss Sallie Myles

(Address) 855 Harlem Ave

15 Filed MAR 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1923. to date of death, that I last saw h[illegible] alive on March 25 1923. and that death occurred, on the date stated above, at 3 20 a m.

The CAUSE OF DEATH* was as follows:

Death was due to
Cerebral apoplexy
(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Sidney La Davis, M. D.

, 19 (Address) 827 N. Hutton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	March 27 1923

20 UNDERTAKER Robert S. Little ADDRESS 1700 Edmondson ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74126

D74126

CERTIFICATE OF DEATH.

49

D74126
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 N. Eden St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Harry D. Greenwood

(a) Residence No. 1412 N Eden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? 52 yrs. 8 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Greenwood

6-DATE OF BIRTH (month, day and year) Jan 17 1870

7-AGE, 52 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Collector

(b) General nature of Industry, business, or establishment in which employed (or employer): Installment House

(c) Name of employer: Isaac Benesch & Sons

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER, Walter Greenwood

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Margarette Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14-

(Informant) Francis Greenwood

(Address) 2265 N. Baltimore St

15- Filed MAR 25 1923, 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23, 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 13, 19.., to March 23, 19.23, that I last saw him alive on March 23, 19.23, and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Duration) 7 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) General Metastasis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? John Dafrock

(Signed) John Dafrock, M. D.

March 24 1923 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cem. — DATE OF BURIAL, Mar. 26th 19.23

20-UNDERTAKER, George Schulting & Sons — ADDRESS 1166 E Monument St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74127

HEALTH DEPARTMENT—CITY OF BALTIMORE

7412)

CERTIFICATE OF DEATH.

D74127 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 248 S. Third St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Lloyd Castine

(Residence in Baltimore: No. Rosedale, Balto. Co. Md. St.; yrs. few minutes ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. December (Month) 25 (Day) 1863 (Year)

7-AGE. 59 yrs. 3 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Emanuel Castine

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Laura Batchelor

13-BIRTHPLACE OF MOTHER, (State or Country). Balto., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eugene E. Graham

(Address) 1913 E. North Avenue

15 Filed MAR 25 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mch 23rd (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. B. Horton M. D.
Coroner.

Mch 24th 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence. Rosedale, Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	3/26 19 23

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

IT IS VERY IMPORTANT that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74128

D74128

CERTIFICATE OF DEATH.

31

D74128

1-PLACE OF DEATH Bayview Hospital 21 Registered No.....

City of BALTIMORE: (No.....St., 21 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A ~~Grimm~~ Grimm

(a) Residence No. 1152 Montpelier St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Minnie Grimm

6-DATE OF BIRTH (month, day and year) Oct 26, 1859

7-AGE. 63 yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Butcher

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, Adam Grimm

11-BIRTHPLACE OF FATHER (city or town)..... Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Webber

13-BIRTHPLACE OF MOTHER (city or town)..... Germany
(State or Country),

14-(Informant)..... Hospital Records

(Address).....

MAR 25 1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 23/23

17- I HEREBY CERTIFY, That I attended deceased from 3/17/23, 19.. to 3/23/23, 19..
that I last saw him alive on 3/23/23, 19..
and that death occurred, on the date stated above, at 10.50 p. m.
The CAUSE OF DEATH* was as follows:

chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) alcoholism

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis?.....

(Signed) J. A. Lucke, M. D.

Mar 24 1923 (Address) Bayview Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park	Mar 26 1923
20-UNDERTAKER.	ADDRESS
Mrs Nes John W Teufel & Son	801 W. Fayette

Should be carefully supplied. Not always necessary to answer in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Pulmonary Tuberculosis
5-6 Mos.
See letter on File
(Mr. Moore) under
Dr. J McKay.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74129

HEALTH DEPARTMENT—CITY OF BALTIMORE

74129

CERTIFICATE OF DEATH.

D74129 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3016 Tyndale Ave St., 27 46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa E Green

(a) Residence No. 3016 Tyndale Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William E Green

6-DATE OF BIRTH (month, day and year) Dec 29 1869

7-AGE. 53 yrs. 4 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Oscar Hilleyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Eleanor Bishop

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Mrs Green

(Address) 3016 Tyndale Ave

15- MAR 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 24/23

17- I HEREBY CERTIFY, That I attended deceased from Jan 23 1923 to Mar 23 1923 that I last saw her alive on Mar 23 1923 and that death occurred, on the date stated above, at 12.05 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus with metastasis to intestine and abdominal wall

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 30/22

Was there an autopsy? No

What test confirmed diagnosis? Phys

(Signed) Wm C Stifler M. D

3/24 1923 (Address) 1319 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Mar 26 1923

20-UNDERTAKER, George J Smith — ADDRESS 1532 Hollins St

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21 MAT 1500 lbs.

Thomas Harrison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74130

CERTIFICATE OF DEATH. X 86-001 D74136

1-PLACE OF DEATH Church Home & Inf- REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Broadway & Fairmount WARD)

2-FULL NAME Master Thomas Harrison

(a) RESIDENCE NO. Lighman Island ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct - 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	12	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Lighman Island (State or country)

PARENTS

10 NAME OF FATHER John B. Harrison

11 BIRTHPLACE OF FATHER (city or town) Lighman (State or country) Island

12 MAIDEN NAME OF MOTHER Lottie E Conway

13 BIRTHPLACE OF MOTHER (city or town) Lighman Island (State or country)

14 Informant (Address) John B Harrison Lighman Island

15 MAR 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1923, to March 24, 1923, that I last saw him alive on March 24, 1923, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis.

Edema Lungs.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Methods

(Signed) E. G Coblentz, M. D.

(Address) C. N. D. O

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lighman M E Cemetery

DATE OF BURIAL March 27 1923

20 UNDERTAKER Bernard W Fuhr

ADDRESS 1 E Columbia ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 74131

D74131

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. I687 Darley Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Friedericka Siebert

(a) RESIDENCE NO. I687 Darley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. A: Siebert

6 DATE OF BIRTH (month, day, and year) 9/28/1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Hartman Diemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johannah Menger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm A: Siebert

(Address) 1687 Darley Ave

15 Filed MAR 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 22, 1923, to Mar. 24, 1923, that I last saw her alive on Mar. 25, 1923, and that death occurred, on the date stated above, at 12.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Rivlock M.D.

3-25-1923 (Address) 1512 Mortimer

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL March 27, 23

20 UNDERTAKER John Ullrich

ADDRESS 2008 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74132

D74132

CERTIFICATE OF DEATH. 101-001

D74132

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 678 W. Saratoga ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Dalphonze.

(a) RESIDENCE. No. 678 W. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July-5-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Luigi Dalphonze

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Eva D'Addario

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Eva Dalphonze
(Address) 678 W. Saratoga St.

15 MAR 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17

I HEREBY CERTIFY, That I attended deceased from March 9 -, 1923, to March 24 -, 1923; that I last saw h~~im~~ alive on March 23 -, 1923, and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows:

Migratory Pneumonia.

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chester Riland, M. D.

3-24, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cathedral	Mar 26 1923
20 UNDERTAKER John Dillard	ADDRESS 2008 Aisquith

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

12728 D74133

HEALTH DEPARTMENT—CITY OF BALTIMORE D74133

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 N—Central ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessy Dent.

(a) RESIDENCE NO. 437 N—Central ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) House Work 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Philip

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harriett Thomas
(Address) 437 N Central Ave

15 FILED MAR 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22- 1923

17

I HEREBY CERTIFY, That I attended deceased from 3-12-, 1923, to 3-22-, 1923, that I last saw h[illegible] alive on 3-22-, 1923, and that death occurred, on the date stated above, at 7,30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulites

(duration) Indefinite yrs mos ds.

CONTRIBUTORY (Secondary) Intermittent Nephritis

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Hargett, M. D.

3-23, 1923 (Address) 611-N- Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 26, 23
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725- Oakland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74134

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D74134

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Burns

(Residence in Baltimore: No. 1747 Ashland Ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (write the word.)
male	black	Married

6-DATE OF BIRTH. APRIL 19/1861 (Month) (Day) (Year)

7-AGE. 61 yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. James A. Burns

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Julienne unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James M'. Burns (son)

(Address) 50 Hopkins St. Waterbury Conn.

Filed MAR 26 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) undetermined

(Duration) yrs. mos. ds.

(Signed) J. S. Gutman M. D. (Coroner.)

3/23/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Asbury	March 27 1923
20-UNDERTAKER, John W Henderson	ADDRESS 1502 E Monument

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74135

91-002 D74135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 S Spring st., ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Mack

(a) RESIDENCE NO. 26 S. Spring ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Edet Mack

6 DATE OF BIRTH (month, day, and year) Feb 1 1853

7 AGE: Years 70 | Months 1 | Days 23 | If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jim Snider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adeline Snider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Smith

(Address) 504 N Eutaw Ave

15 Filed MAR 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1923, to March 24, 1923, that I last saw h[illegible] alive on March 22, 1923, and that death occurred, on the date stated above, at 2 AM m.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

, 19 (Address) 1517 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: March 26 1923

20 UNDERTAKER John W Henderson — ADDRESS 1502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3623 Mapley Ave Ward 3 160)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Betty J Greeley

(a) Residence No. 3623 Mapley Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 18 1923

7-AGE. ✓ yrs. ✓ mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John W Greeley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elsie Frock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) John W Greeley (Address) 3623 Mapley Ave

15- Filed MAR 26 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25 1923

17- I HEREBY CERTIFY, That I attended deceased from 3/18, 1923 to 3/25, 1923 that I last saw h[er] alive on 3/25, 1923 and that death occurred, on the date stated above, at 3. A m. The CAUSE OF DEATH* was as follows:

Acute Myelogenous Leukemia

(Duration) ....yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Abdominal Hemorrhage

(Duration) ....yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) C. F. Carlson, M. D.

3/25, 19 (Address) 3701 Gray Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Laters Balto — DATE OF BURIAL, March 26, 1923

20-UNDERTAKER, Chenoweth & Son — ADDRESS Chestnut St Ave

Exact statement of OCCUPATION is very important. See that it is carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Endorse on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74137

CERTIFICATE OF DEATH.

90 D74137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 E Hoffman ST., 14 WARD)

2-FULL NAME Margaret C Hall

(a) RESIDENCE NO. 1504 E Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: James J. Hall

6 DATE OF BIRTH (month, day, and year): July 22-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Winchester Va (State or country)

PARENTS

10 NAME OF FATHER Joseph Schumm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant (Address) James J. Hall. 1504 E Hoffman st

15 MAR 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1923

17 I HEREBY CERTIFY That I attended deceased from March 19, 1923, to March 24, 1923, that I last saw h alive on March 23, 1923; and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency 3 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? ....

(Signed) J E Schumm M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wood Lawn Cem'y — DATE OF BURIAL: March 26, 23

20 UNDERTAKER: Robt G Turner Jr — ADDRESS: 1442 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. If ... it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74138

CERTIFICATE OF DEATH.

49 D74138

1-PLACE OF DEATH Church Home and Inf

CITY OF BALTIMORE: (No. 176 N. Broadway ST., 8 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Brooks

(a) RESIDENCE NO. 1406 N. Broadway ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruola R Brooks

6 DATE OF BIRTH (month, day, and year) Mar 1- 1846

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacconist

(b) General nature of industry, business, or establishment in which employed (or employer) Newport News Va

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newport News Va

PARENTS

10 NAME OF FATHER James R Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ruola R Brooks
(Address) 1406 N Broadway

15 MAR 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 24, 1923, that I last saw him alive on March 24, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

a Bronchopneumonia

b Nephritis, Chronic

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) c Carcinoma Prostate

b Carcinoma a Femur

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? X Ray & Autopsy

(Signed) Richard S Coblentz, M. D.

(Address) C H S

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Way Side Va	Mar 26, 23
20 UNDERTAKER Robt Jenness Sec	ADDRESS 1402 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74139

CERTIFICATE OF DEATH.

101-001

D74139

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 45 Maryland Ave West 25th ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Klein.

(a) RESIDENCE. No. 45 Maryland Ave. Westport. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Klein

6 DATE OF BIRTH (month, day, and year) Sept. 19-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER George Phillip

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Hurest.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Louis A. H. Klein
(Address) Towson Md

15 Filed MAR 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 18, 1923, to Mar 23, 1923, that I last saw h[illegible] alive on Mar 23, 1923, and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Lemmon, M. D.

3/26, 1923 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Mar 26 1923
20 UNDERTAKER	ADDRESS
N. Sanders & Sons	1710 Eutaw St.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D74140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74140

CERTIFICATE OF DEATH.

182

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. Foot of Ann St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick L. Westinghausen

(Residence in Baltimore: No. 528 So. Decker ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. May (Month) 9th (Day) 1856 (Year)

7-AGE. 66 yrs. 10 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer). 606

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Gustav. Westinghausen

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Louise Brockman

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pauline Westinghausen

(Address) 528 So. Decker Ave

15-

Filed MAR 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22nd (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and ..... (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Had an attack of indigestion & fell off wharf

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. B. Horton M. D.
(Coroner)

March 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Paul's Cemetery	Mar. 26 1923
20-UNDERTAKER,	ADDRESS
H. Sander & Sons	1710 Fleet St

Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Saulsbury.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74141

CERTIFICATE OF DEATH.

D74141

1-PLACE OF DEATH Bayview Hospital

City of BALTIMORE: (No. ..... St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliphalet Saulsbury

(a) Residence No. 1108 Woodyear St St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not known

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not known

11- (Informant) Hospital Records

(Address) .....

15- Filed MAR 26 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/24/23

17- I HEREBY CERTIFY, That I attended deceased from 3/17/23, 19 .... to 3/24/23, 19 .....

that I last saw h[illegible] alive on 3/17/23, 19 .....

and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows: —

Chronic nephritis

(Duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) ..... yrs. ..... mos. 10 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. a. McKay M. D.

, 19 (Address) .....

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. West Lawn. DATE OF BURIAL. Mar. 27, 1923

20-UNDERTAKER. James N. Davis ADDRESS Freeman

Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74142

CERTIFICATE OF DEATH.

X 129

D74142

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1820 Linden ave ST., 14 WARD)

2-FULL NAME Mary Lerenthal

(a) RESIDENCE NO. 1830 Linden ave ST., WARD California

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Lerenthal

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

15 MAR 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 — 24 — 23

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 19 23, to March 24, 19 23, that I last saw h alive on March 23, 19 23, and that death occurred, on the date stated above, at 1.10 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine 6 M. D.

March 25, 19 23 (Address) 14 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bath Hebrew Cem

DATE OF BURIAL 3/26 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Garage

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74143

CERTIFICATE OF DEATH.

90 D74143

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 14 WARD)

2-FULL NAME Mrs. Perry Hannah Savage.

(a) RESIDENCE NO. 1719 Madison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard M Savage Deceased

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

15 Filed MAR 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1923

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 25 1923.

that I last saw h[illegible] alive on March 25 1923,

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Uremia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Auricular fibrillation - Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Moses Gellman, M. D.

March 25 1923 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 3/26/1923

20 UNDERTAKER

ADDRESS Jack Lewis 1439 E Baltimore St

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74144

CERTIFICATE OF DEATH.

D74144

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Marshall Court (St.) Brooklyn

2-FULL NAME Hilbert Fairbanks

(a) RESIDENCE NO. Marshall Court Brooklyn WARD 25
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 5 mos. 21 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma V. Fairbanks

6 DATE OF BIRTH (month, day, and year) Oct. 2 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer 156

(b) General nature of Industry, business, or establishment in which employed (or employer) E. Brooklyn Box Co.

(c) Name of employer E. B. Box Co.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Fairbanks

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Clagmonter

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Charles Cunningham
(Address)

15 FILED MAR 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from March. 15, 1923, to March 23, 1923, that I last saw him alive on March. 23, 1923, and that death occurred, on the date stated above, at 9.55 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William A. Fort, M. D.

, 19 (Address) 816 Pennington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar. 26 1923
20 UNDERTAKER	ADDRESS
George L. Schwab & Son Eutaw Inc.	

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74145

REGISTERED No. D74145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2741 N Calvert St ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie M. Finnan

(a) RESIDENCE NO. 2741 N Calvert St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Eugene J. Finnan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Rosalie LeFaivre

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Eugene J. Finnan

(Address): 2741 N. Calvert St

15 Filed MAR 26 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to March 25, 1923, that I last saw her alive on March 25, 1923 and that death occurred, on the date stated above, at 11.45 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Throat Disease

(Signed) Walter C Bacon, M. D.

3/25, 1923 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 3-26 1923

20 UNDERTAKER: Henry W Jenkins Sons Co — ADDRESS: McCulloh & Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74146

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 N Stricker ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Allen Figg

(a) RESIDENCE. NO. 1110 N. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Figg

6 DATE OF BIRTH (month, day, and year) 9-19-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sarah Tunnel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

11 Informant J. Allen Figg

(Address) 1110 N Stricker St

15 MAR 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 26, 1922, to Mch 24, 1923, that I last saw h[illegible] alive on Mch 24, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Greater curvature) with metastases in liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry S. McCarty, M. D.

, 19 (Address) 137 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Mar 27, 1923
20 UNDERTAKER	ADDRESS
C. F. McCormick —	508 E. London Ave

N. B.—WHITE PLAINLY. WRITE ONLY IN BLACK INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Kate J. Weaver

HEALTH DEPARTMENT--CITY OF BALTIMORE

D74147

CERTIFICATE OF DEATH

90 D74147

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 930 Bennett Place ST. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs Kate J. Weaver

(Residence in Baltimore: No. 930 Bennett Place ST.)

59 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~DIVORCED~~ (Write the word): Widow

6 DATE OF BIRTH: [illegible], 1 (Month) (Day) (Year)

7 AGE: 59 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Stone
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John C Ledley

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rebecca F. Pindell

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kary C. Weaver

(Addres) 930 Bennett Place

15 MAR 26 1923 191

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 25, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1 1922 to March 25 1923 that I saw h-er alive on March 24 1923 and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

do not know

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) ... yrs. 10 mos. ... ds.

(Signed) R L Kupfer M. D.

(Address) 1923 Westwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park DATE OF BURIAL: MAR 28 1923 191

20 UNDERTAKER: Geo W Little ADDRESS 0 EDMONDSON AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74148

CERTIFICATE OF DEATH.

D74148

1-PLACE OF DEATH

City of BALTIMORE: (No. 357 Rosebank St., 27 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Slack Miller

(a) Residence No. 357 Rosebank St., 27 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? 72 yrs. 4 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Augusta Nelson Miller

6-DATE OF BIRTH (month, day and year) Oct-31-1850

7-AGE. 72 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber

(c) Name of employer Self

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER. David Miller

11-BIRTHPLACE OF FATHER (city or town) Cecil Co (State or Country) Penna

12-MAIDEN NAME OF MOTHER. Amanda Slack

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Maryland

14- (Informant) Mrs Augusta N. Miller (Wife) (Address) 357 Rosebank Ave.

15- MAR 26 1923 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25 / 23

17- I HEREBY CERTIFY, That I attended deceased from Feb 25 1923 to March 25 1923

that I last saw him alive on March 25 1923

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? c

Did an operation precede death? No Date of c

Was there an autopsy? No

What test confirmed diagnosis? Chem. & Microscopic

(Signed) August Hoen M. D

, 19 (Address) 402 E 25th

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. March 28 1923

20-UNDERTAKER. STEUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. NOTE—Words to be written in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74149

CERTIFICATE OF DEATH.

90 D74149

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Farrell

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD. Yonkers N. York -
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. 0 mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Cert	83	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Religious -
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic - 063
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) unknown

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Baltimore Md -

15 Filed MAR 26 1923 19 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1890, 19..., to March 25th, 1923, that I last saw h[illegible] alive on March 25th, 1923, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:
Chr Bronchitis - Complicated by Myocarditis

abt (duration) 8 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -
owr (duration) 53 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Yonkers N. York -

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.
, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
New Cathedral Cemetery

DATE OF BURIAL
Mar 26th 1923

20 UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS
103 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74150

CERTIFICATE OF DEATH.

91-002 D74150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore and Payson Sts

CITY OF BALTIMORE: (No. German Aged Home St.: 70 WARD)

2-FULL NAME Margaret E O'Donald

(a) RESIDENCE. NO. German Aged Home ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1835

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Edward Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) U S

12 MAIDEN NAME OF MOTHER Elizabeth Cassell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U S.

14 Informant (Address) Records German Aged Home Baltimore and Payson Sts

15 Filed MAR 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to March 25, 1923, that I last saw h[illegible] alive on March 24, 1923, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Lanoff, M. D.

(Address) 1573 W. Balto. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar 27 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W Balto St

Blanks Should Be Carefully Supplied. All Questions Should Be Answered. EXACT AGE, PHYSICIANS Should State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D74151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1565 Richland ST., 13 WARD)

2-FULL NAME Eliza F. Larrimore

(a) RESIDENCE NO. 1565 Richland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas F. Larrimore

6 DATE OF BIRTH (month, day, and year): Apr. 21 1857

7 AGE: Years 65; Months 11; Days 3; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Kevin Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Fairbank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ralph D. Larrimore

(Address) 1565 Richland St

15 MAR 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 18, 1923, to Mar. 24, 1923,

that I last saw her, alive on mar 24, 1923,

and that death occurred, on the date stated above, at 12 20 m.

The CAUSE OF DEATH* was as follows:

Septic infection of Larynx followed by General Sepsis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Septic infection an

foci (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Local infection & General Symptoms of Septicemia

(Signed) Wm. F. Phillips, M. D.

19 (Address) 2300 Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boaman Md

DATE OF BURIAL: Mar 26 23

20 UNDERTAKER: Wm. F. Lickenbrock Home

ADDRESS: North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74152

CERTIFICATE OF DEATH.

185 D74152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Meyers

(a) RESIDENCE NO. 2018 Evergreen Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Meyers

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	73	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Ellecamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Enderstadt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. W. E. Kemper

(Address) 2018 Evergreen Terrace

15 MAR 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to March 24, 1923,

that I last saw her alive on March 24, 1923,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

1. Fracture Femur accidental (Fall)

2. Chronic Myocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 30 min.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Hubert Jackson, M. D.

, 19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 27 1923

20 UNDERTAKER W. J. Richardson — ADDRESS Balto

mation should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY, and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall down steps.
Certificate Issued O.K.
by Coroner Hennessy
on Telephone
J. Kelleher

O.K
3/20 Dis. T. Hennessy
Dis. Coroner

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74153

CERTIFICATE OF DEATH.

D74153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N Chester St ST., 6 WARD)

REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Betty Rosenstein

(a) RESIDENCE NO. 103 N Chester St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Rosenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Lottie Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Jack Lewis 1439 E Baltimore

15 FILED MAR 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1923

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 25, 1923, that I last saw h[illegible] alive on March 25, 1923, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Baylis, M. D.

3/25, 1923 (Address) 20 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrens Frendyk Cem

DATE OF BURIAL 3/26 1923

20 UNDERTAKER Jack Lewis 1439 E Baltimore

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74154 — 47 ✓ D74154

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Delaney

(a) RESIDENCE NO. ~~Bay View Asylum.~~ 508 W. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or ~~divorced~~ WIFE of (or) ~~WIFE of~~ James D. Delaney

6 DATE OF BIRTH (month, day, and year) ~~1872~~ 1/2/1871

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
~~80~~ 52	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Athme

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Sims

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Md.

12 MAIDEN NAME OF MOTHER: Jane Quick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Md.

14 Informant: ~~Mrs. Temple Hospital~~ Hospital Records. (Address) 2107 Etting St.

15 MAR 26 1923 ROBERT P. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1923 to March 22 1923, that I last saw her alive on March 22, 1923, and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma breast

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) ..... yrs. ..... mos. 1 wk ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. McCoy M. D.

3-23-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Mar 26 1923
20 UNDERTAKER	ADDRESS
Jno. M. Johnson	1234 Etting St.

mation should be carefully supplied. Age should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74155

CERTIFICATE OF DEATH.

D74155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3705 Eastern Ave St.; 76 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Rose

(Residence in Baltimore: No. 3705 Eastern Ave St.; ..... yrs., 2 mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, October 29, 1857 (Month) (Day) (Year)

7-AGE, 65 yrs. 4 mos. 23 da. If LESS than 1 day, ...hrs. or ....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Lansing Mich.

PARENTS.

10-NAME OF FATHER, Frank Rose

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Belle Rose

(Address) 3705 Eastern Ave

15- MAR 26 1923 ROBERT R. KRAUTER,
Filed ....., 191.... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH March 24, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1923 to March 24 1923, that I saw h— alive on March 24 1923, and that death occurred, on the date stated above, at 5308 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. 2 da.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) Horace B Tilson M. D.

3/25, 1923 (Address) 3 N S. Highland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence Lansing Michigan

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lansing Mich.	Mar. 29, 1923

20-UNDERTAKER	ADDRESS
Harry H Limacott	4244 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74156

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST., 17 WARD)

2-FULL NAME Baby Schmidt

(a) RESIDENCE NO. 209 W 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Harry Schmidt

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Brenley

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Southern Hospital
(Address)

15 MAR 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1923, to March 24, 1923,
that I last saw li[ve] alive on March 24, 1923;
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? ...

(Signed) John A O'Connor, M. D.
19 (Address) South Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	March 26, 1923
20 UNDERTAKER	ADDRESS
C A Weidefeld Jr	501 E 22d

mation should be carefully supplied. AGE should be stated EXACTLY. If infant, NAME should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74157

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74157

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Tydings

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) July 9th 1841

7-AGE. 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Chas. Tydings

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New Orleans

12-MAIDEN NAME OF MOTHER, Julia Tydings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Orleans

14- (Informant) Municipal Hospital Records

(Address)

15- MAR 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 16, 1923 to March 23, 1923

that I last saw h. im alive on March 23, 1923

and that death occurred, on the date stated above, at 9:40 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 9 0 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

3-23-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cemetery	3/26, 1923
20-UNDERTAKER.	**ADDRESS**
E. J. Fanning & Son	1938 E Lafayette Ave

Blanks to be carefully filled out in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

Wm Miles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74158 ✓ 71-001 D74158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 0 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mr. Miles

(a) Residence No. Woodbine Maryland St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 8-1871

7-AGE. 51 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer 86

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Albert Miles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Walker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital Record

(Address).....

15- Filed ~~MAR~~ SEP 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25-23

17- I HEREBY CERTIFY, That I attended deceased from March 17, 1923 to March 25, 1923

that I last saw h[illegible] alive on March 25, 1923

and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Carbuncle of upper lip

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Meningitis

Septicemia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of March 23

Was there an autopsy? No opening of Carbuncle

What test confirmed diagnosis? Special pustules

(Signed) Daniel J Deasy M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Cure from Crem Mt Olivet	3-27, 1923
20-UNDERTAKER.	ADDRESS
E & B Hahn	115 E Lexington

Should be carefully supplied, Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74159

CERTIFICATE OF DEATH.

113 D74159

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital ST., 27 WARD)

2-FULL NAME Baby Sahm

(a) RESIDENCE NO. Stewart Ave Mt. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Luther Sahm

11 BIRTHPLACE OF FATHER (city or town) Frederick
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Evelyn Myers

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland.

14 Informant Evelyn Sahm
(Address) Stewart Ave. Mt. Wash Hgts.

15 Filed MAR 26 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 13, 1923 to Mar 25, 1923,

that I last saw h[illegible] alive on Mar 25, 1923,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical.

(Signed) George E. Shannon, M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL March 26, 1923

20 UNDERTAKER W M Rountree

ADDRESS 2235 Pa. Ave.

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74160

CERTIFICATE OF DEATH.

90 D74160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 W Franklin ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Jane Smith

(a) RESIDENCE NO. 1627 W Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Smith

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Marys County (State or country) Md.

PARENTS

10 NAME OF FATHER James Williams

11 BIRTHPLACE OF FATHER (city or town) St Marys County (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Francis Williams

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co (State or country) Md

14 Informant William Phillip Williams (Address) 1702 W Lafayette Av.

15 MAR 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 13, 1923, to Mar 24, 1923, that I last saw h[illegible] alive on Mar 24, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Wallace Frey, M. D.

3/26, 1923 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft Celeste Cem

DATE OF BURIAL 3-27 1923

20 UNDERTAKER Daniel Easter

ADDRESS 916 Pine

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74161

D74161

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 11 E. Biddle Apt. ST.: 73 WARD)

2-FULL NAME Martha Doran

(a) RESIDENCE. NO. 1820 S. Charles ST., 73 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced (or) WIFE of Hub Adrian

6 DATE OF BIRTH (month, day, and year) — — 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Hitzi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hub Adrian (Address) 1820 S. Charles St.

15 MAR 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1923, to March 25, 1923, that I last saw her alive on March 25, 1923, and that death occurred, on the date stated above, at 8:10 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. Schmunck M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	3/27 1923
20 UNDERTAKER John A Kaufmann	ADDRESS 35 Light St.

MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION should be given. Words like "Laborer," "Housewife," "Clerk," etc., alone are indefinite. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 90

D74162

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bayview Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME anna Spealman

(a) Residence No. 136 East ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 73 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Quinder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Hospital Records

(Address)

15- MAR 26 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/24/23

17- I HEREBY CERTIFY, That I attended deceased from 3/16/23 19.. to 3/24/23 19..

that I last saw h.er alive on 3/24/23 19..

and that death occurred, on the date stated above, at 7.05 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Strat Failure

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

. 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Pacific Heart Co	March 26, 1923
20-UNDERTAKER. Lilly & Zeller	ADDRESS 403 S. Wolfe St.

Should be strictly observed. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74163

CERTIFICATE OF DEATH.

100-001

D74163

REGISTERED NO.

1-PLACE OF DEATH St Vincents Infant Asy.

CITY OF BALTIMORE: (No. 1401- Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Smith

(a) RESIDENCE No. 1401 Division St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Nov. 12 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marion Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant St Vincents Inf Asylum

(Address) 1401 Division St

15 MAR 26 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1923, to March 24, 1923,

that I last saw h.. alive on March 24, 1923,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. R. Goldsborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	March 27 1923
20 UNDERTAKER	ADDRESS
Martin Gahey & Son	827 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Wm a Zaun

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74164

CERTIFICATE OF DEATH.

#9

REGISTERED NO. D74164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2315 James H Harrell Pk St.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm a Zaun

(Residence in Baltimore: No. 2315 James Harrell Park St.; 50 yrs. mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 13 (Day), 1863 (Year)

7-AGE, 59 yrs. 8 mos. 13 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Justus Zaun

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Maria Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm a Zaun

(Address) 2315 Harrell Pk

15- Filed MAR 26 1923, 191 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1922, to March 24 1923, that I saw h[illegible] alive on March 23 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hydrothorax

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Supposed of cancerous origin

(Duration) yrs. mos. ds.

(Signed) Thos B Hall M. D.

3. 25, 1923 (Address) Halethorp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem

DATE OF BURIAL, 3 26, 1923

20-UNDERTAKER H Heemann

ADDRESS 322 Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74165 D74165

CERTIFICATE OF DEATH.

90 D74165

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1714 Druid Hill Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Flora Brown.

(Residence in Baltimore: No. 1714 Druid Hill Ave. or 90 yrs. — mos. — da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) Unknown (Day) ....., 1830 (Year)

7-AGE, 93 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Frederick Md

PARENTS.

10-NAME OF FATHER, Isaac Epperson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Edwards

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie Pague

(Address) 1714 Druid Hill Ave

15- Filed MAR 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Mar. (Day) 24, 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 17 1923, to Mar. 24 1923, that I saw h[illegible] alive on Mar. 23 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 7 yrs. — mos. — da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ..... yrs. 6 mos. ..... da.

(Signed) W. T. Carr M. D.

Mar. 26, 1923 (Address) 515 Mosher St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Frederick Md

DATE OF BURIAL, 3/27/23

20-UNDERTAKER Samuel Hemsley

ADDRESS McDade

Spec.—1-10-21—M&T—1500 Bks.

D74166 HEALTH DEPARTMENT—CITY OF BALTIMORE D74166

6 CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Fairmount Av ST., 5 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olden Seammbe

(a) RESIDENCE NO. 1412 Fairmount Av ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 4/1896

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
26	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in O&O

(b) General nature of industry, business, or establishment in which employed (or employer) steel mill

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Jim Spriggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Lula Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Lilly Diggs
(Address) 1412 Fairmount Av

15 MAR 27 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25/ 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 24, 1923, to Mar 25/, 1923, that I last saw h alive on Mar 24, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Richard L Eushner, M. D.

(Address) 1514 E Dale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL at Bury cemetery

DATE OF BURIAL 27 march 1923.

20 UNDERTAKER Edward Bryson

ADDRESS 631 orleans st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74167

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4009 Resterstown Rd (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel M. Phillips

(a) RESIDENCE NO. 4009 Resterstown Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wade Phillips

6 DATE OF BIRTH (month, day, and year) Jany 7 1893

7 AGE Years 30 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED None 37

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Wm a Dam

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ida M. Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Wm A Dam

(Address) 4009 Resterstown Rd

15 MAR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1922, to March 25, 1923, that I last saw her alive on March 24, 1923, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from leg ulcer

(duration) about 24 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. L. Sugiura M. D.

19 (Address) 2439 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL Mar 27 1923

20 UNDERTAKER E. Cook Johnson

ADDRESS 1 W. Lanvale

mation should be carefully supplied. AGE should be stated EXACTLY. Information must be complete. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103 D74168

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No.. ..... ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Mathews

(a) RESIDENCE No 1124 Argyle Ave. ..... ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (Husband of or) WIFE of Frederick V. Mathews

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raleigh North Carolina

PARENTS

10 NAME OF FATHER Wm. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Emma Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Dead

15 Filed MAR 27 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 21 1923 to March 23 1923 that I last saw her alive on March 23 1923 and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Alkalosis following prolonged vomiting

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Bugg M. D.

3/27 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn

DATE OF BURIAL MAR 27 1923

20 UNDERTAKER Samuel Hemsley

ADDRESS 578 Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause Unknown

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74169 1-PLACE OF DEATH

38

D74169 REGISTERED NO. C

CITY OF BALTIMORE: (No. 1021 Carolton Ave St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Steve Hamilton

(Residence in Baltimore: No. 1021 Carolton ave St.; 8 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1877 (Year)

7-AGE, 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hamilton (wife)

(Address) 1021 Carolton av

15-

Filed ....., 191. ROBERT R. KRAUTER, Registrar.

MAR 27 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 11 1923, to March 25 1923, that I saw h[illegible] alive on March 25 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... (Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) yrs. mos. ds.

(Signed) C. E. Daughety M. D.

Mar 26, 1923 (Address) 1662 Bush St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, MAR 27 1923

20-UNDERTAKER Samuel T Hemsley — ADDRESS 578 W Baltimore St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D74170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74170

CERTIFICATE OF DEATH.

REGISTERED NO. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Bridgewood ST.; 15 WARD)

2-FULL NAME Flora J. Bennett.

(a) RESIDENCE. No. 1903 Bridgewood ST. 15 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) 1/15/1912

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	11	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thos. Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Dora Schroder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Dora L. Bennett,
(Address) 2123 Bridgewood Ave

15 FILED MAR 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-22, 1923, to 3-24, 1923

that I last saw her alive on 3-24, 1923

and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Ulman M. D.

3/25/23 (Address) 2757 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	3/27/23

20 UNDERTAKER Geo. J. Ruth ADDRESS 1730 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74171

CERTIFICATE OF DEATH.

100-001

D74171

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 554 W. Conway ST., 22 WARD)

2-FULL NAME Melvin Morgan

(a) RESIDENCE NO. 554 W Conway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) Arundel
(State or country) County

PARENTS

10 NAME OF FATHER James Morgan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Anne Arundel County

12 MAIDEN NAME OF MOTHER Sarah Settle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Anne Arundel County

14 Informant James Morgan
(Address) 554 Conway St

15 Filed MAR 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923. to March 24. 1923.
that I last saw him alive on March 24. 1923.
and that death occurred, on the date stated above, at 9.35 P. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. H. Bennett, M. D.

3-25. 1923 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Mar 1923

20 UNDERTAKER Jno. Grieves & Son

ADDRESS 706 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74172

CERTIFICATE OF DEATH.

D74172

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HADDIE GORMAN GAMBRILL

(a) RESIDENCE NO. UNION MEMORIAL HOSPITAL ST., 14 WARD (near Laurel, Howard Co.)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? 53 yrs. 9 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Gorman Gambrill

6 DATE OF BIRTH (month, day, and year) June-21-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) near Laurel
(State or country) Howard Co., Md.

PARENTS

10 NAME OF FATHER Arthur Pue Gorman

11 BIRTHPLACE OF FATHER (city or town) near Laurel
(State or country) Howard Co., Md.

12 MAIDEN NAME OF MOTHER Haddie Donagan

13 BIRTHPLACE OF MOTHER (city or town) Laurel
(State or country) Howard Co., Md.

14 Informant (husband)
(Address) near Laurel, Howard Co., Md.

15 FILED MAR 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-27-1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 9, 1923, to Mar. 27, 1923, that I last saw her alive on Mar 27, 1923, and that death occurred, on the date stated above, at 1 30 a.m.

The CAUSE OF DEATH* was as follows:

Acute intestinal obstruction

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Bronchi-pneumonia (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Mar 9th 23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A.B. Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington, D.C. DATE OF BURIAL March-29-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AV

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60-002

D74173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1614 St Joseph St (St.:) 8 (Ward)

2-FULL NAME Eliza Garrison

(a) RESIDENCE. No. 1614 St Joseph St (St.:) (Ward.)

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	col.	widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Preston Garrison

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) (State or country) Darlington S. C.

PARENTS

10 NAME OF FATHER Campbell Garden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Garden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Walter Garrison (Address) 1614 St Joseph St

15 Filed MAR 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 24 Mar. 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/22/23 to 24/3/23 that I last saw ~~him~~ her alive on 4/3/23 and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows: Coxitis, tuberculosis aneurysm, myocarditis.

(duration) unknown

CONTRIBUTORY (Secondary) Ruptured aneurysm

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home Nurse.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mayfield Boyd, M. D.

(Address) 1211 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairmont	Mar 26 1923

20 UNDERTAKER ADDRESS

R B Gross 1405 Mc Elderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74174 — 129 — D74174

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospl ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary ~~Mainz~~ Mainz

(a) RESIDENCE NO. 1909 W Mulberry ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Mainz.

6 DATE OF BIRTH (month, day, and year) 7/25/55

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Bross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant ~~Sister~~ Helen Rice

(Address) 138 S. East Ave

15 Filed MAR 27 1923, 19 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/23

17 I HEREBY CERTIFY, That I attended deceased from 3/8/23, 19.... to 3/26/23, 19.... that I last saw her alive on 3/26/23, 19.... and that death occurred, on the date stated above, at 5 45 p.m.

The CAUSE OF DEATH* was as follows:

Uremic poisoning

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical Finding

(Signed) Jno A Simpkins, M. D.

19 (Address) 710 Gentry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 28 1923
20 UNDERTAKER	ADDRESS
Jos Joerders Son	2178 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. Attending physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 S. East Ave | St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Eardley

(a) RESIDENCE NO. 300 S. East Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Solomon Eardley

6 DATE OF BIRTH (month, day, and year) 1-16-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	74	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

~~(c) Name of employer~~

9 BIRTHPLACE (city or town) London

(State or country) England

PARENTS

10 NAME OF FATHER Herbert Henderson

11 BIRTHPLACE OF FATHER (city or town) London

(State or country) England

12 MAIDEN NAME OF MOTHER Mary Bentley

13 BIRTHPLACE OF MOTHER (city or town) London

(State or country) England

14 Informant Beatrice Eardley

(Address) 300 S. East ave

15 Filed MAR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/21, 1923, to 3/25, 1923,

that I last saw h~~e~~ alive on 3/25, 1923,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis and Myocardial Discompensation

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C A Reifschneider, M. D.

3/ , 19 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL 3-27 1923

20 UNDERTAKER Henry W Jenkins & Sons

ADDRESS Mitchell & Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74176

CERTIFICATE OF DEATH.

47 D74176

REGISTERED NO.

1-PLACE OF DEATH Guilford

CITY OF BALTIMORE: (No. 3 Bedford Pl ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Gill Mallinckrodt

(a) RESIDENCE NO. 3 Bedford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND OF~~ (or) WIFE of L. K. Mallinckrodt

6 DATE OF BIRTH (month, day, and year) 11-18-1879

7 AGE: Years 43; Months; Days; If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady 037

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: McGilles Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto - Md

12 MAIDEN NAME OF MOTHER: Alice Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Md

14 Informant (Address): L. K. Mallinckrodt Guilford

15 Filed MAR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Mar 26, 1923, that I last saw h alive on March 25, 1923, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ch—
Lungs

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of breast

Operation (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of About 1 year ago

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam

(Signed) Julius Friedman, M. D.

Mar 27 1923 (Address) 10 13 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 3-28 1923

20 UNDERTAKER: Henry W. Justice & Sons

ADDRESS: Baltimore

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D74177

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Winchester

(a) RESIDENCE NO. University Club ST. Madison & Chas WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) 2-14-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	74	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ptd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Winchester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Baltimore

15 Filed MAR 27 1923 ROBERT R. KRAUSE, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1923

17

I HEREBY CERTIFY, That I attended deceased from March 12, 1923, to Mch 26, 1923, that I last saw h alive on Mch 26, 1923, and that death occurred, on the date stated above, at 4:35 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma - stomach

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mch 23-23

Was there an autopsy? No

What test confirmed diagnosis? Section for diagnosis

(Signed) Warfield M Theobald, M. D.

3/26 1923 (Address) Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL March 28 1923

20 UNDERTAKER A. W. Jenkins Sons Co. ADDRESS Orchard nr Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. If infant, NUMBER OF HOURS or MINUTES may be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74178 ✓ X 129 D74178

D74178 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 S. East Ave ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Hansen M. D.

(a) RESIDENCE NO. 705 S. East Ave ST., WARD Germany.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emelia Hansen

6 DATE OF BIRTH (month, day, and year) Aug. 4-1860.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 54

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Hansen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Emelia J. Hansen (Address) 705 S. East Ave.

15 Filed MAR 27 1923 ROBERT A. KEMPFER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to March 24, 1923,

that I last saw him alive on March 24, 1923,

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Aspiratio intestitialis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Apoplexia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Anamayer M. D.

, 19 (Address) 2438 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL Mch 27 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74179

CERTIFICATE OF DEATH.

11-002 D74179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Shelter for Aged Colored Persons 517 N. Eddle St — ST., 17 WARD)

2-FULL NAME Mary Madden

(a) RESIDENCE NO. Same as above ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 + yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~77~~	77 +			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 670

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hampton, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Julie M. Bowdoin (Address) Edbridge, Md

15 Filed MAR 27 1923 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to March 22, 1923, that I last saw her alive on March 22, 1923, and that death occurred, ~~on the date stated above~~ Mar. 26, 1923 at 6:30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

Myocardial insufficiency

(duration) 1 + yrs. mos ds.

CONTRIBUTORY (Secondary)

Grippe (duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical examination

(Signed) Mary A. Hodge M. D.

, 19 (Address) 943 N. Calvert St Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Mch 27 1923

20 UNDERTAKER Chas E. Franck ADDRESS 807 Madison Av

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate as nearly as possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74180

CERTIFICATE OF DEATH.

1 161-001 D74180

Registered No. C.....

CERTIFICATE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanora Eisel

(Residence in Baltimore: No. 636 S. Ellwood Ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write Word.)
female	white	single

6-DATE OF BIRTH. March 19 1923
(Month) (Day) (Year)

7-AGE. .....yrs. .....mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Harry Eisel

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Nellie Levy

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H.D. Clogg

(Address) 1035 N. Gay St.

15-

DATE MAR 27 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. WYJWE---26/23 19:.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition- Premature Birth

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Wolfe M. D.
(Coroner.)
3/26/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	March 27, 1923
20-UNDERTAKER.	ADDRESS
H. M. Routson	2235 N. ~~Fulton~~ Fulton

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 D74181

D74181

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 S. Schroeder ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Linn —

(Residence in Baltimore: No. 127 S Schroder St.; 50 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: March 25 th, 1847
(Month) (Day) (Year)

7-AGE: 76 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Joseph Hunel

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Barbara Nistein

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Knell

(Address) 917 Columbia Ave

15-

Filed MAR 27 1923, 191.. ROBERT P. KRAUSE Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: March — 25 —, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov — 1922, to March 25 — 1923, that I saw h— alive on March 24 1923, and that death occurred, on the date stated above, at 8-a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis et Asthma —

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) general debility —

(Duration) yrs. 1 mos. ds.

(Signed) Frank O Bruner M. D.

3/27 —, 1923. (Address) 125 S Broy —

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Mar. 28 1923

20-UNDERTAKER: Knell & Son

ADDRESS 1729 W Pratt st

Spec. 1-10-21—MAT—1500 Blks.

D74182 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 William St. ST., 24 WARD)

2-FULL NAME Susan Elizabeth Hayward

(a) RESIDENCE NO. 1021 William St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hayward

6 DATE OF BIRTH (month, day, and year) Oct. 12 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mary J. Wroten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William Hayward (Son)

(Address) 1021 William St.

15 Filed MAR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 23, 1923, to Mar 26, 1923,

that I last saw her alive on March 25, 1923,

and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) W. A. Smith, M. D.

Mar 27, 1923 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Mar 30 23

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 MAT 1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74183

CERTIFICATE OF DEATH.

D74183

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 Warren Avenue ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Henrietta Morgan

(a) RESIDENCE NO. 121 Warren Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E. Morgan

6 DATE OF BIRTH (month, day, and year) Sep't 12 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	73	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William A. Tarleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Henrietta Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant James T. Morgan (Son)

(Address) 1643 N. Bentalou

15 MAR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1923, to Mar 26, 1923,

that I last saw h... alive on Mar 25, 1923,

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Contusion

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ... M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Mar 28 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. ETHNICAL group should be given so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis

Spec.—1-10-21—M&T—1500 Blks.

D74184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-001 D74184

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Harlem Ave. ST., 16 WARD)

2-FULL NAME Franklin Whalen

(a) RESIDENCE No. 1500 Harlem Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. — How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Priscilla J. Fulton

6 DATE OF BIRTH (month, day, and year) Dec. 10. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Whole-sale Hardware

(c) Name of employer Carlin Fulton Hdw Co

9 BIRTHPLACE (city or town) (State or country) Howard Co Md.

PARENTS

10 NAME OF FATHER John Whalen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dr. Fulton Whalen

(Address) 2304 Whitelock ave

15 Filed MAR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1918, to March 25. 1923

that I last saw h~~e~~ alive on March 25, 1923

and that death occurred, on the date stated above, at 6 55 p m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

about (duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Exam.

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Mch 28 1923
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Miskimon ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74185 HEALTH DEPARTMENT—CITY OF BALTIMORE 57 D74185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 N. Castle ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George P. Miskimmon

(a) RESIDENCE. NO. 918 N. Castle ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Park School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Philip Miskimmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) 918 N. Castle St

15 MAR 27 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922, to March 25, 1923, that I last saw him alive on March 24, 1923, and that death occurred, on the date stated above, at 2.00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic (Parenchymatous) Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus and Lobular Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis P. Krauss, M. D.

, 19 (Address) 2500 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	3/27 1923
20 UNDERTAKER Philip Herring	ADDRESS 1016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74186

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 W Baltimore ST., 20 WARD)

2-FULL NAME Patrick F Ward

(a) RESIDENCE NO. 2025 W Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 3 mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec-(?) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	3	(?)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter D50

(b) General nature of industry, business, or establishment in which employed (or employer) Painting

(c) Name of employer United Railways & Elec Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bernard Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Delaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Sinnard

(Address) 2025 W Balto St

15 Filed MAR 27 1923, 19 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 . 1923 . to March 25 . 1923.

that I last saw him alive on Mar 24 . 1923.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1½ yrs. mos da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? T.B Positive.

(Signed) C F Buxton. M. D.

3/20, 1923 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Mar 28 1923

20 UNDERTAKER J J Curran & Son ADDRESS 901 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74187

CERTIFICATE OF DEATH.

16 54 D74187

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Stevenson

(a) Residence No. ? St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ?

7-AGE, 44 45 yrs. ? mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework D

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

11- (Informant) Municipal Hospital Records

(Address).....

MAR 27 1923 Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 24, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 21, 19 23 to March 24, 19 23.

that I last saw her alive on March 24, 19 23.

and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Pellagra

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) J. A. Mella M. D.

3-26-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19..
Mt Auburn	March 28
20-UNDERTAKER	ADDRESS
L. L. Brown's Son	101 N. Monroe St

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16233 — D74188

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74188

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7 WARD)

2-FULL NAME Nathan Katz.

(a) RESIDENCE NO. 205 Carlisle Ave ST., WARD York Pa. York, Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898 - April 5.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 042

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) York Pa.

PARENTS

10 NAME OF FATHER Samuel Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Rena Rosenbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Hospital Records (Address) JOHNS HOPKINS HOSPITAL.

15 MAR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1923, to March 26, 1923, that I last saw him alive on March 26, 1923, and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus meningitis

(duration) yrs. mos 1 7 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs. 1 mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 20, 23.

Was there an autopsy? No.

What test confirmed diagnosis? Cultures of spinal fluid.

(Signed) B Strauman, M. D.

3-26 1923. (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York, Penna — DATE OF BURIAL Mar 28 1923

20 UNDERTAKER J. M. Cook — ADDRESS 502 E. North Ave.

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74189

101-001 D74189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 N. Wolfe ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rhoda Stein

(a) RESIDENCE NO. 113 North Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 26, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Jacob Stien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Goldie Madofsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Stien

(Address) 118 N. Wolfe St.

15 Filed MAR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1923, to March 26, 1923, that I last saw her alive on March 26, 1923, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas J Bayless, M. D.

3/27, 1923 (Address) 20 W Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Montefiore

DATE OF BURIAL 3/27 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74190

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Simmons

(a) RESIDENCE. No. 1623 Baker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Simmons

6 DATE OF BIRTH (month, day, and year) August 21st Unknown 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John J. Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edward Simmons (Address) 1623 Baker St.

15 Filed MAR 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1923, to March 26, 1923, that I last saw him alive on March 26, 1923, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) John D. Quinn, M. D.

3/26. 1923. (Address) 507 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar 23 1923
20 UNDERTAKER	ADDRESS 517
Henry C Brannigan Sons	Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Aletha Hilt ✓

D74191 HEALTH DEPARTMENT—CITY OF BALTIMORE D74191

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Wilcom al. ST., 77 WARD)

2-FULL NAME Aletha Hilt

(a) RESIDENCE NO. 108 Wilcom al. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Hilt

6 DATE OF BIRTH (month, day, and year) May 29 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55	—	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 87

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. (State or country) Md.

PARENTS

10 NAME OF FATHER John Child

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Md

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. (State or country) Md

14 Informant Alice Hilt
(Address) 108 Wilcom al

15 MAR 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1923, to Mar 23, 1923, that I last saw h[er] alive on Mar 23, 1923, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W. H. Arnold, M. D.

Mary, 19 (Address) 109 N. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	3/27 1923
20 UNDERTAKER P. L. Parham	ADDRESS 220 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. OCCUPATIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74192 HEALTH DEPARTMENT—CITY OF BALTIMORE D74192

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1065 Falls Road St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia C Cabell

(Residence in Baltimore: No. 1065 Falls Road St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Jan (Month) 19 (Day) 1[illegible] (Year)

7-AGE: 74 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Charles F Dale

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Mary S Dukes

13-BIRTHPLACE OF MOTHER, (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christopher C Cabell

(Address) 1065 Falls Road

15- Filed MAR 27 1923 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 26 (Day) 192[illegible] (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pa Bronchitis
Pneumonia
Exhaustion
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

(Date) MAR 26 192[illegible] (Address) 2211 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park DATE OF BURIAL: March 28 1923

20-UNDERTAKER: William Cook ADDRESS: 582 E North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

[illegible] Monument Roland Ave.

D74193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D74193

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1713 Ensor St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Butz

(Residence in Baltimore: No. 1713 Ensor St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, (Write the word.)
male	white	married

6-DATE OF BIRTH. Dec 27/1861 (Month) (Day) (Year)

7-AGE. 61 yrs. 2 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John Butz

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Butz

(Address) 1713 Ensor St.

15- MAR 27 1923 192 ROBERT M. KNOX Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Asthenia-
(Intermittant vomiting of blood
for several months)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastric ulcer or carcinoma. (Duration) yrs. mos. ds.

(Signed) J. H. Fuller M. D. (Coroner.)

3/26/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL. March 28 1923

20-UNDERTAKER. Henry Storch Son — ADDRESS 1301 E. Eager St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74194

CERTIFICATE OF DEATH.

143-103 D74194

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Franklin Square Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Brendel (Gardenville)

(a) RESIDENCE No. 14 Eutaw Pl. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin J. Brendel

6 DATE OF BIRTH (month, day, and year) June 16 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Knoedler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mathilde Bruscher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D C

14 Informant M. Martin J. Brendel (Address) 14 Eutaw Pl

15 MAR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1923, to Mar 27, 1923, that I last saw h.. alive on Mar 27 4P 1923 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Extra Uterine Pregnancy (duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Tubal Rupture & Hemorrhage (duration) yrs. mos. 3 days

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) J. M. Stevens, M. D.

(Address) 1278 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 29 23
20 UNDERTAKER	ADDRESS
Henry Hoerle Son	1391 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74195

CERTIFICATE OF DEATH.

37 D74195

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST.: W WARD)

2-FULL NAME Gertrude Horigan.

(a) RESIDENCE. No. 2204 N. Charles ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude E. Horigan

6 DATE OF BIRTH (month, day, and year) Feby 18-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) Business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Dennis Horigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Gertrude E. Horigan

(Address) 2204 N. Charles St

15 MAR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 26, 1923, that I last saw h[illegible] alive on March 26, 1923, and that death occurred, on the date stated above, at 5.05 p, m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Hemorrhagic Nephritis

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 6/23

Removal Stone in Kidney

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S W Kinney, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	3/29 1923

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W Mt Royal Ave

INSTRUCTIONS: This certificate should be carefully supplied. ALL questions should be answered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Renal Calculus

Spec.—1-10-21—M&T—1500 Blks.

(Penilton)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74196

CERTIFICATE OF DEATH.

D74196

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 Dolphin St., 11 WARD)

2-FULL NAME John C Penilton

(a) RESIDENCE NO. 144 Dolphin St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U.S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
male	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Balf

6 DATE OF BIRTH (month, day, and year) Oct 1 1922

7 AGE — Years	6 Months	24 Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Non

(b) General nature of industry, business, or establishment in which employed (or employer) Non

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Luis Walker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Julia Penilton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mother, Julia Penilton
(Address) 144 Dolphin St Balt

15 Filed MAR 27 1923, 19..... Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1923, to March 25 1923, that I last saw h~~is~~ alive on March 24, 1923, and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
following Whooping
Cough & Malnutrition.

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough & Malnutrition (duration) ..... yrs. ..... mos ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geo Kull, M. D.

, 19 (Address) 1466 E 23 d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 1923
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Oakland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16730r

D74197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74197

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 1 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. William R. Campbell

(a) RESIDENCE No. 315 E. Ohio St. Canton Ino. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Lavinia Campbell

6 DATE OF BIRTH (month, day, and year) Sept 7 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Al. W. ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill.

12 MAIDEN NAME OF MOTHER Elsie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant Johns Hopkins Hospital (Address) Peoria.

15 Filed MAR 27 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1923, to March 26, 1923, that I last saw him alive on March 26, 1923, and that death occurred, on the date stated above, at 6 00 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor (glioma)

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Clinton. Wis.

Did an operation precede death? Yes Date of Mar. 23, 1923

Was there an autopsy? Yes (partial)

What test confirmed diagnosis?

(Signed) P B MacCready, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lipton Ill. DATE OF BURIAL March 29 1923

20 UNDERTAKER Wm. C. Black ADDRESS 2711 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00 D74198

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1114 S. Clinton St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William C. Dranbauer, Jr.

(a) Residence No. 1114 S. Clinton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov. 18- 1921

7-AGE. 1 yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. C. Dranbauer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Agatha Marowski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Wm. C. Dranbauer

(Address) 1114 S. Clinton St.

15- Robert P. Harrison,

Filed March 27, 1923 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 26-1923

17- I HEREBY CERTIFY, That I attended deceased from March 25 1923 to March 26 1923

that I last saw him alive on March 25 1923

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchial Epld

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D

March 27, 1923 (Address) 14 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL, March 28, 1923

20-UNDERTAKER, Zirkler & Zirkler ADDRESS 1739 E. Eager St.

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Should be carefully supplied. Also given in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74199

D74199

CERTIFICATE OF DEATH.

102

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 E. Eager ST., 7 WARD)

2-FULL NAME Theodore H. Wack

(a) RESIDENCE NO. 1737 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 68 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Marie P. Wack

6 DATE OF BIRTH (month, day, and year) July 25 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	87	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 015

(b) General nature of industry, business, or establishment in which employed (or employer) (Carpenter)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Theodore Wack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Decker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie P. Wack

(Address) 1737 E. Eager St.

15 Robert P. Harrison, .19 Registrar

Burial Permit Clerk.

MAR 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to March 27, 1923, that I last saw him alive on March 27, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Epistaxis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm A Sage, M. D.

3/27, 1923 (Address) 702 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Mch 29, 1923

UNDERTAKER Burkhardt & Burkhardt — ADDRESS 1739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74200

HEALTH DEPARTMENT—CITY OF BALTIMORE

117

D74200

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Gen Hosp ST., 25 WARD)

2-FULL NAME Melvin C. Anderson

(a) RESIDENCE NO. 115 7 4th St Brooklyn Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 30 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Acid Tester

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Davison Chemical Co

9 BIRTHPLACE (city or town) Brooklyn (State or country) Md

PARENTS

10 NAME OF FATHER Charles R. Anderson

11 BIRTHPLACE OF FATHER (city or town) Brooklyn (State or country) Md

12 MAIDEN NAME OF MOTHER Magdalena Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant James E Anderson (Uncle)

(Address) Brooklyn, Baltimore

15 Filed MAR 27 1923, 19.....

Robert F. Bartram Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 27, 1923, that I last saw him alive on March 27, 1923, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis (?)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Operation - Ruptured Appendix (duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death? Home - 115 N. 4th St.,

Did an operation precede death? Yes Date of 3/7/23

Was there an autopsy? No - Parents refused Examination

What test confirmed diagnosis?

(Signed) John A. Cameron, M. D.

(Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL March 29 '23

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

AGE should be carefully supplied. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74201

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74201

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH 1640 Clarkson 23

CITY OF BALTIMORE: (No. ... St., ... Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P Heidereich

(a) RESIDENCE NO. 1640 Clarkson ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 8 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Heidereich

6 DATE OF BIRTH (month, day, and year) July 26-1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
49	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer 045

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lewis Heidereich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Matilda Deuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant (Address) John P Heidereich 1640 Clarkson St.

15 Filed MAR 27 1923 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1922 to March, 1923, that I last saw h[e] alive on March 23, 1923 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J H Hyatt, M. D.

19 (Address) 356 Montgomery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery a. v.	March 28 1923
20 UNDERTAKER	ADDRESS
Margaret A. Flynn	1422 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can bo ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

D74202 HEALTH DEPARTMENT—CITY OF BALTIMORE D74202

CERTIFICATE OF DEATH. 101-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 805 Vincent St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Rose Sisco

(Residence in Baltimore: No. 805 Vincent St. St.; 11 yrs.....mos.....ds.)

X

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	widow

6-DATE OF BIRTH. about (Month) ..... (Day) 1887 (Year)

7-AGE, 36 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... 041

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. W. Dist. Police

(Address) Penna Ave -

15- Robert P. Harrison

Filed ..... 192..... Registrar.

27 1923 Burial Permit Clerk.

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) No history.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

March 16 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY DATE OF BURIAL, ...

20-UNDERTAKER, Commissioner Health, ADDRESS MAR 27 1923

D74203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74203

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Bond St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Unknown

6-DATE OF BIRTH. Unknown (Month) (Day) 1..... (Year)

7-AGE. About 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15-

Filed Robert P. Harrison, Registrar.

MAR 27 1923

Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 13th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained at said Inquest, aforesaid, and from the Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Supposed Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fell overboard

(Duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.

Mch 26 1923. (Address) Curtis Bay Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY

DATE OF BURIAL. MAR 27 1923

20-UNDERTAKER.

ADDRESS

Commissioner Health.

MAR 27 1923

Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be understood.

D74204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74204

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 878 ST.John's Alley St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Jones

(Residence in Baltimore: No. 878 St. John's Alley St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	black	single

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
about 40 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country).
Md.

PARENTS.

10-NAME OF FATHER. John Jones

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Annie unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Robert P. Harrison. 192

Burial Permit Clerk. Registrar.

MAR 27 1923

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

3/9/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY. DATE OF BURIAL. 19....

20-UNDERTAKER. ADDRESS

Commissioner Health. MAR 27 1923

Every item of information should be carefully supplied. AGE should be stated EXACTLY. Space for OCCUPATION must be filled. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Space for OCCUPATION must be filled. state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D74205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D74205

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maly. ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bab. Durace

(Residence in Baltimore: No. 0 St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. X

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 3 - 25 - 23, 1 (Month) (Day) (Year)

7-AGE, 2 hrs. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), West End Maly

PARENTS.

10-NAME OF FATHER, Wm Durace

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Sadie Crime

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Filed MAR 27 1923, 191.....

Robert P. Harrison, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 - 26 - 23, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 25 1923, to Mar 26 1923, that I saw h e alive on Mar 25 1923, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both Lungs.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Thomas M. D.

Mar 26, 1923 (Address) 1224 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER .....

ADDRESS .....

Commissioner Health, MAR 27 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

0243

Spec—12-23-21—E.B.R.S.—400 Blks.

D74206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74206

CERTIFICATE OF DEATH.

161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Berger.

(a) Residence No. 115 E. Mulberry St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 3-23-23.

7-AGE. .....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or 35 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Samuel Berger

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Anna Saudler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

11-

(Informant)

(Address)

Robert P. Harrison, JOHNS HOPKINS HOSPITAL

12-

13-

MAR 27 1923 Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-23-23

17- I HEREBY CERTIFY, That I attended deceased from March 23 1923 to May 23 1923

that I last saw [illegible] alive on March 23 1923

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) A. J. Bruce M. D.

, 19 (Address) Med. & Path.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL. ..... 19...

20-UNDERTAKER. Commissioner Health,

ADDRESS. MAR 27 1923

Dr. WM. E. WOODALL

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Filled. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74207 HEALTH DEPARTMENT—CITY OF BALTIMORE D74207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital 15 86-001 Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Leary.

(a) Residence No. 3726 Park Heights Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male. | 4-COLOR OR RACE, White. | 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 2 1915

7-AGE, 8 yrs. 1 mos. 24 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) (None)
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Daniel J. Leary

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Georgiana Decker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mercy Hospital Records

(Address).....

15- Robert P. Harrison, Registrar.

Filed MAR 27 1923 192? Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 26 23

17- I HEREBY CERTIFY, That I attended deceased from March 25 19 23 to Mar. 26 19 23

that I last saw h[illegible] alive on March 26. 19 23

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Mastoiditis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Septic Meningitis (Streptococcus)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery | DATE OF BURIAL, 3/28/, 19 23

20-UNDERTAKER. Henry W. Mears & Son | ADDRESS 805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. ANY UNKNOWN ITEM should be stated as such. Exact statement of OCCUPATION is very important. Cause of death must be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74208

CERTIFICATE OF DEATH.

101-001

D74208

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3702 Dorchester Road) (Ward 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Mallonee

(a) RESIDENCE. No. 3702 Dorchester Road Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? 53 yrs. 1 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of B. Gertrude Mallonee

6 DATE OF BIRTH (month, day, and year) Feb. 07 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Owner of Dairy

(b) General nature of industry, business, or establishment in which employed (or employer) Milk 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Ephriam Mallonee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Ambrose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E. Butler

(Address) 2563 Hazelwood Ave

15 Filed MAR 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 27, 1923, to March 26, 1923, that I last saw ~~MAN~~ alive on March 26, 1923, and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Asthenia

(duration) about yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Double Lobar Pneumonia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. R. Johnson, M. D.

3/26, 1923 (Address) 3929 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: MAR 29 1923

20 UNDERTAKER: Geo W. Little

ADDRESS 4000 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rabid Cameron.

(a) RESIDENCE NO. 1626 N. Calvert St. City ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single (Parents)

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Cameron

Thomas & Catherine ~~Dean~~

6 DATE OF BIRTH (month, day, and year) Oct 18, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) (")

(c) Name of employer (")

9 BIRTHPLACE (city or town) (") (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Cameron

11 BIRTHPLACE OF FATHER (city or town) (") (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine McDonal

13 BIRTHPLACE OF MOTHER (city or town) (") (State or country) U.S.

14 Informant Johns Hopkins Hospital Records (Address)

15 Filed March 27 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1923, to March 26, 1923, that I last saw him alive on March 26, 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Hector Caspers M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/28 1923

20 UNDERTAKER Henry W. Meas & Son

ADDRESS 105 Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D74210

CERTIFICATE OF DEATH.

D74210

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 Hanover ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll G. Poole

(a) RESIDENCE NO. 1533 Hanover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 2- 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer) not any

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm S Poole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bertha A Hasley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm S Poole

(Address) 1533 Hanover St

15 MAR 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1923

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to Mar 27, 1923,

that I last saw he alive on Mar 27, 1923,

and that death occurred, on the date stated above, at 1:0 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Convulsion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo Buxton, M. D.

3/27, 1923 (Address) 301 E 6th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	3/28 1923
20 UNDERTAKER L. F. McAnally	ADDRESS 1806 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 906 So Harris Alley St., 1 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcella C. Salazer

(Residence in Baltimore: No. 906 So Harris Alley St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Sept 22nd 1922 (Month) (Day) (Year)

7-AGE: 0 yrs. 6 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Joseph S. Salazer

11-BIRTHPLACE OF FATHER, (State or Country): So. America

12-MAIDEN NAME OF MOTHER: Gioreta Boston

13-BIRTHPLACE OF MOTHER, (State or Country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gioreta Salazer

(Address) 906 So. Harris Alley

15-

Filed MAR 28 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March 27th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) 1 yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. Buxton Cor M. D. (Coroner)

Mch 27th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Stanislaus Cem DATE OF BURIAL: Mar 28 1923

20-UNDERTAKER: Stephen L Frackowski ADDRESS 100 Glenwood

Spec.—1-10-21—M&T—1500 Blks.

D74212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D74212

REGISTERED NO.....

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (NO. 17 ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Brooks

(a) RESIDENCE NO. 1341 Penna Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	74(?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James Bordley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records
(Address)

15 MAR 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/23 19

17 I HEREBY CERTIFY, That I attended deceased from 3/1/23, 19 ..... to 3/25/23, 19 .....,

that I last saw her alive on 3/25/23, 19 .....,

and that death occurred, on the date stated above, at 3 00 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. A. McKay M. D.

3/26/23 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Mar 29 19 23

20 UNDERTAKER Chris. J. Johnson ADDRESS 417 N. Carlton St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74213

CERTIFICATE OF DEATH.

74-001 D74213

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Division ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaiah P. Brown Sr

(Residence in Baltimore: No. 1307 Division St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1869
(Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer): Dealer

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Perry Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lorraine Brown

(Address) ~~2005 W.~~ 1307 Division

15-Filed MAR 28 1923 191... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 23, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 18 1923, to March 23 1923, that I saw h[illegible] alive on March 23 1923, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 4 yrs. mos. ds.

(Signed) H S McCard M. D.

3/28, 1923 (Address) 1005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn Cem

DATE OF BURIAL, 3/28/23, 191...

20-UNDERTAKER Saml J Hemsley

ADDRESS 5738 Belair

N. B.—Every item of information should be carefully inquired. Ages, names of parents, etc., should be obtained if possible. CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

1625 D74214

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D74214

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Dorothy Wojcik

(a) RESIDENCE No. 1611 Fleet St. City ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos., ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Agnes Wojcik.

6 DATE OF BIRTH (month, day, and year) Sept 24, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	6	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland,

PARENTS

10 NAME OF FATHER Peter Wojcik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Wittes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 MAR 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923.

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1923, to March 27, 1923, that I last saw her alive on March 27, 1923, and that death occurred, on the date stated above, at 12 00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. mos 20 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray.

(Signed) Horton Casparis, M. D.

3/27, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Mar. 28 1923

UNDERTAKER William Fairfowler 1618 ADDRESS Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mumma

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74215

CERTIFICATE OF DEATH.

1925 D74215

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital (St.) 12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgianna Mumma

(Residence in Baltimore: No.) Fort Avenue (St.) 73 yrs. 1 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: February 17 (Month) (Day) 1845 (Year)

7-AGE: 78 yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS:

10-NAME OF FATHER: Chas Mayers

11-BIRTHPLACE OF FATHER, (State or Country): Prussia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Phillip Sprd

(Address) Clifton Ave & 9th St

15-

FILED MAR 28 1925 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 27 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Typhoid Pneumonia

four days

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Fracture of Femur

(Duration) 2 Weeks mos. ....ds.

Contributed to accidentally Fall in home

(Signed) [illegible] M. D.

(Coroner.)

Mar 28 1923. (Address) 1659 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 29 1923
UNDERTAKER	ADDRESS
[illegible]	Mt Ch & Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Fractions should be stated that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74216

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74216

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1369 Gilmor ST., 15 WARD)

2-FULL NAME Robert Harris Jr.

(a) RESIDENCE NO. 1369 Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Aug 12/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Robt Harris Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Hattie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Hattie Harris 1369 Gilmor

15 Rec'd MAR 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1923, to Mar 27, 1923, that I last saw him alive on Mar 27, 1923 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)

..... (duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. Wallace Frey, M. D.

3/28, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mch 28 1923
20 UNDERTAKER	ADDRESS
Samuel H. Black Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20 D74217

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 632 W. Fayette St. St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Bernard Silbermann.

(Residence in Baltimore: No. 632 W. Fayette St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Jan. (Month) 16 (Day) 1920 (Year)

7-AGE. 3 yrs. 2 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). B. Cely

PARENTS.

10-NAME OF FATHER. Phil Silverman

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Jennie Lundberg

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Balto

15- Filed MAR 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Suffocation: ~~Smothered~~ Toy Balloon lodged in trachea

(Duration) yrs. a few mos. ds.

CONTRIBUTORY (Secondary) Accident

(Duration) yrs. mos. ds.

(Signed) W. H. Feemal M. D. (Coroner.)

3-28 1923 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Olivet Cemetery. DATE OF BURIAL. 3-29-23

20-UNDERTAKER. Jacot Funeral Co. ADDRESS 1439 E. Balto.

Spec.—1-10-21—M&T—1500 Bks.

D74218

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 Nanticoke ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Mann Meekins

(a) RESIDENCE No. 1131 Nanticoke ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 1 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alvin M Meekins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Edith R Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Alvin M Meekins

(Address) 1131 Nanticoke St

15 MAR 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 23 1923 to Mar 27 1923, that I last saw h[illegible] alive on Mar 27 1923, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? no Date of "

Was there an autopsy? no

What test confirmed diagnosis? "

(Signed) G E Buxton M. D.

3/28. 1923 (Address) 306 E Lenox St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	March 30 1923
UNDERTAKER	ADDRESS
A Howard Evans	143 E Lenox St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74219

CERTIFICATE OF DEATH.

90 D74219

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Hanover ST., 23 WARD)

2-FULL NAME Joseph. Geo. Nieman

(a) RESIDENCE NO. 1208 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Nieman

6 DATE OF BIRTH (month, day, and year) Sept 15 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer.

(b) General nature of industry, business, or establishment in which employed (or employer) 134

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jos. G. Nieman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Pottgeser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Carrie Nieman. (Address) 1208 Hanover St

15 Filed MAR 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1923, to March 26, 1923, that I last saw him alive on March 26, 1923, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 3-29 1923

20 UNDERTAKER E & B Horle — ADDRESS 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74220

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D74220

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 19 WARD)

2-FULL NAME Lloyd Disney

(a) RESIDENCE NO. 1417 W Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE Mrs Miranda Disney

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) " "

14 Informant Mrs Miranda Disney Wife
(Address) 1417 W Mulberry St.

15 MAR 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8 1923, to March 26, 1923.

that I last saw him alive on March 26, 1923,

and that death occurred, on the date stated above, at 8 PM m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Miller Safe Co

Did an operation precede death? no Date of .....

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Moses Faulson, M. D.

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mrs. Chas. G. Rohde

UNDERTAKER Geo. M. London Park Cem

DATE OF BURIAL 4-2 19

ADDRESS Irvington Md.

N. B.—WHITE PAPER, WITH CONTRIBUTORY AGE should be carefully supplied. AGE mation should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-09 D74221

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1725 E. Federal ST., 8 WARD)

2-FULL NAME Anna Bieler

(a) RESIDENCE NO. 1725 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if of foreign birth? 59 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of dec'd Albert Bieler

6 DATE OF BIRTH (month, day, and year) Sept 12 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Totenbush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mary Betzel

(Address) 1725 E. Federal St

15 Filed MAR 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1923, to Mar 27, 1923, that I last saw h alive on Mar 27 1923 and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Suspected

(Signed) J. W. Simms, M. D.

(Address) 1727 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: March 29, 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAPER MUST NOT BE SOILED OR MUTILATED. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, TION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74222

CERTIFICATE OF DEATH.

11-002

D74222

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 716 Cedar ave ST.: 4 WARD)

2-FULL NAME Charlotte Banks

(a) RESIDENCE. NO. 716 Cider ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress 41
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Charles Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Julia Wilson
(Address) 406 Mosher St.

15 Filed MAR 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit (No.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/1923

17 I HEREBY CERTIFY, That I attended deceased from 3/22/1923, to 3/26/1923, that I last saw her alive on 3/26/1923, and that death occurred, on the date stated above, at 12:40 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Finney Smith M. D.

3/27/1923 (Address) 908 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mont auburn	March 29 1923
20 UNDERTAKER	ADDRESS
John H Owens	538 Dolphin

be stated EXACTLY. PHYSICIANS should state
y be properly classified. Exact statement of OCCUPA-
k of certificates.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of c

Spec.—1-10-21—M&T—1500 blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74223

CERTIFICATE OF DEATH.

D74223

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 24 (WARD)

2-FULL NAME John Peltz

(a) RESIDENCE NO. 1510 Byrd st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mins.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John peltz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ella Barth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed MAR 28 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1923, to March 27, 1923, that I last saw him alive on March 27, 1923, and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances K. Fullerton, M. D.

3-28-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	March 28 23
20 UNDERTAKER	ADDRESS
Fred Lassahn & Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74224

CERTIFICATE OF DEATH.

D74224

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 10 Ward) 90

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Crawford

(a) Residence No. 10 2/8 Hillman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 28 73

7-AGE. 50 yrs. 11 mos. 25 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) 048

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Moore Town

PARENTS

10-NAME OF FATHER, Saml T. Crawford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Delaware

12-MAIDEN NAME OF MOTHER, Emily Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mary M. McDermott

(Address) 612 E. 30th St

15- Filed MAR 28 1923 ROBERT R. VEASEY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 27 23

17- I HEREBY CERTIFY, That I attended deceased from Mar 22 19 23 to Mar 27 19 23

that I last saw h[illegible] alive on Mar 26 19 23

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. J. Scaggs, M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cemetery, DATE OF BURIAL, March 29 1923

20-UNDERTAKER, Geo. J. Ruth, ADDRESS 1735 Hayford ave

N. B. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74225

CERTIFICATE OF DEATH.

49 D74225

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Roeder

(a) Residence No. 1005 E. Pratt St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of married

6-DATE OF BIRTH (month, day and year) 1857

7-AGE. 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Talbert Co., Md.

PARENTS.

10-NAME OF FATHER, Charles Roeder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

14- (Informant) Municipal Hospital Records

(Address)

15- FILED MAR 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 9, 1923 to March 27 1923 that I last saw h.. im alive on March 27 1923 and that death occurred, on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma Lung

(Duration) yrs. 4-5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

3-27-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Trinity Cemetery	Mar 29, 1923
20-UNDERTAKER.	ADDRESS
Wm Cook Sons &	Mont Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74226

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH St. Agnes Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 17 WARD)

2-FULL NAME Joseph Deloria

(a) RESIDENCE NO. 2231 Huntington ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced, (write the word)~~
Male	White	married

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Elizabeth Deloria

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 04-5

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Nick Deloria

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Vitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank Deloria

(Address) 2231 Huntington Ave

15 MAR 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27 1923

17

I HEREBY CERTIFY, That I attended deceased from 2-17- 1923 to 3-27- 1923.

that I last saw him alive on 3-27- 1923.

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/17/23

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms urinalysis

(Signed) Karl J. Steinmueller, M. D.

3/27/1923 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cemetery — DATE OF BURIAL May 31, 1923

20 UNDERTAKER Wm Leo Kost — ADDRESS 501 E Fort Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74227

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 2743 Winchester St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Francis Lamman

(a) Residence No. 2743 Winchester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 1850

7-AGE.	If LESS than 1 day.
72 yrs. 4 mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)... None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant)... Mrs. F. Black

(Address) 2743 Winchester St.

15- Filed MAR 28 1923 ROBERT P. KRAUTER Registrar. Burial Permit Clerk

Clerk. Relative 206 Preston St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 27/23

17- I HEREBY CERTIFY, That I attended deceased from March 23, 19 23, to March 27, 19 23

that I last saw h. alive on March 26, 19 23

and that death occurred, on the date stated above, at 1150 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Bronchopneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas F Black, M. D.

March 27, 1923 (Address) 204 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL,

National Cem't March 27, 1923

20-UNDERTAKER, ADDRESS

William Cole Sons E Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. Wm. A. Fisher
715 Park Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74228

CERTIFICATE OF DEATH.

45 D74228

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2915 Norfolk Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... T. Talbott Eubank

(a) Residence No. 2915 Norfolk Ave. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) March 28, 1890

7-AGE, 32 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, R. H. Eubank

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Hettie Scott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Pauline W. Eubank
(Address) 2915 Norfolk Ave

15- Filed MAR 28 1923 ROBERT P. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 27 1923

17- I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to March 27, 1923 that I last saw h. alive on March 27 1923 and that death occurred, on the date stated above, at ... a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Richmond Va

Did an operation precede death? Yes Date of July 17 1922

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam

(Signed) Wm A. Fisher Jr., M. D.

, 19 (Address) 715 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park	3/29/23
20-UNDERTAKER.	ADDRESS
Wm. Cook	502 E. North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Inf of Wm & Carrie Land.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74229

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

9 D74229

Registered No. C.....

City of BALTIMORE: (No. 1415 E. Fayette St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Boy Land

(Residence in Baltimore: No. 1415 E. Fayette St.; yrs., 1 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	black	Single

6-DATE OF BIRTH. March 6/22 1.....
(Month) (Day) (Year)

7-AGE.			If LESS than 1 day,	
1	yrs.	mos. 20 ds.	hrs. or	min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Wm. Land

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Carrie Lumpkin

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Land

(Address) 1415 E. Fayette

15- Filed MAR 28 1923 ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) J. S. H. Callen M. D.
(Coroner.)

3/27/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Bury Cemetery	March 28 1923

20-UNDERTAKER.	ADDRESS.
Edward Bryan	631 Carlton St

Spec.—1-10-21—M&T—1500 Blks.

D74230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74230

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 533 N. Bond ST., 7 WARD)

2-FULL NAME Sarah E. Brown

(a) RESIDENCE NO. 533 N. Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

070

9 BIRTHPLACE (city or town) (State or country): Delaware

PARENTS

10 NAME OF FATHER: Emery Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del.

14 Informant: Mrs Ida L Palmer

(Address): 5330 Bond St

15 Filed MAR 28 1923 19 ROBERT P. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 25 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/19/ 1923, to 3/25 1923,

that I last saw h alive on 3/25/23, 19....,

and that death occurred, on the date stated above, at 4:15 p. m.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Gastritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

3/29/23 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: 3/29/23

20 UNDERTAKER: Robert E Williams — ADDRESS: 15 15 Mc Elderry st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Tuel)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74231

D74231

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St., 25 WARD)

2-FULL NAME Baby Tuel

(a) RESIDENCE NO. St Agnes Hospital St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) March 27 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
1 day		—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Agnes Hospital Balto. Md.

PARENTS

10 NAME OF FATHER William Tuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Margaret B. Phelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant William Tuel

(Address) 104 N. Milton Ave Balto Md

MAR 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1923

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to March 24, 1923, that I last saw him alive on March 24, 1923, and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Premature birth (6 mos.)

Exhaustion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Moses Faulson, M. D.

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prem Catholic Belair	3/28 1923
20 UNDERTAKER J A Moran	ADDRESS 30 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74232 HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D74232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 5 S Fulton Ave St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Theresa White

(a) Residence No. 5 S Fulton Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late John White

6-DATE OF BIRTH (month, day and year) Oct 18 1848

7-AGE. 74 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Frank Gallan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) P J White

(Address) 5 W Fulton Ave

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

MAR 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 27 1923

17- I HEREBY CERTIFY, That I attended deceased from March 22 1922 to March 27 1923

that I last saw h.. alive on 19.23;

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis (5 years)

Raynauds disease

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Clinical

(Signed) Edw A Calahan M. D.

3/28, 1923 (Address) 24 N Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Cathedral Cem.	Mar 31 1923
20-UNDERTAKER.	ADDRESS
Harry H Thomas	4204 Ridgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Items 1 to 13 should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74233

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 Cottage ST.: (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME None Baby Griffin

(a) RESIDENCE. No. 3510 Cottage ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-26-23

7 AGE Years Months Days 1

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas W Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant
(Address)

15 Filed MAR 28 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27- 1923

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to March 27, 1923, that I last saw him alive on March 26, 1923, and that death occurred, on the date stated above, at 6 10 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. D. McCurry, M. D.

(Address) 400 N Rayson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAR 27

I.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74234

D74234

CERTIFICATE OF DEATH. 161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1707 N. Mount St. ST.: 15 WARD)

2-FULL NAME Baby Nash

(a) RESIDENCE. No. 1707 N. Mount St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-26-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Brown Nash

11 BIRTHPLACE OF FATHER (city or town) Chesterfield Co.
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Hardy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) King Williams Co., Va.

14 Informant Lucy Nash
(Address) 1707 N. Mount St JOHNS

15 Filed MAR 28 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27- 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-26-, 1923, to 3-27-, 1923, that I last saw him alive on 3-26-, 1923, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity and insufficient Blood Supply

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Placental Previa

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page M. D.

, 19 (Address) 1700 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: MAR 28 1923

20 UNDERTAKER

Commissioner of Health.

MAR 28 1923

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Entries must be made in ink. Any physician or person making false statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74235 HEALTH DEPARTMENT—CITY OF BALTIMORE D74235

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1519 W. Lombard St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Catherine Kavanaugh

(Residence in Baltimore: No. 1519 W Lombard St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Jan (Month) 13 (Day) 1880 (Year)

7-AGE. 43 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country). Balto City

PARENTS:

10-NAME OF FATHER. Peter Donnelly

11-BIRTHPLACE OF FATHER. (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Elizabeth Clark

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E Donnelly

(Address) 3611 Frederick Ave

15-

Filed ..... 192.....

Robert P. Harrison,
Registrar.

MAR 28 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 27 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. 2 mos.....ds.

CONTRIBUTORY (Secondary) ruptured Coronary Artery (Duration) ....yrs. ....mos. Sudden ds.

(Signed) James M. Hanlon M. D. (Coroner.)

Mar 27 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

New Cathedral Mar 30 1923

20-UNDERTAKER. ADDRESS

Harry A Fitzke 1531 W Lombard St

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74236

D74236

CERTIFICATE OF DEATH.

124

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 E. Madison ST., 11 WARD)

2-FULL NAME Louise Duval

(a) RESIDENCE NO. 106 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 0 mos. 28 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Duval

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	71	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Luther Schoolfield

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Dickehut

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Miss Eleanor M. Duval

(Address) 106 E. Madison Street

15 Filed Robt P. Harrison, Registrar

28 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to March 26, 1923, that I last saw h she alive on March 26, 1923, and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Uremia.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Catarrhal Jaundice

(duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No. Date of March 26

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

. 19 (Address) 101 N Eutaw.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: 3/29 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 46

City of BALTIMORE: (No. 1445 Richmond St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Leuchering

(a) Residence No. 1445 Richmond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: George Leuchering

6-DATE OF BIRTH (month, day and year): Nov 9. 1852

7-AGE. 40 yrs. 4 mos. 19 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 437

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS.

10-NAME OF FATHER: George Heinz.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Anna Marie Nob.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14-

(Informant): Marie Heinrich

(Address): 1322 Linden Ave

15-

Filed: Robert P. Harrison, Registrar.

MAR 28 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 28 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28 1922 to March 28 1923

that I last saw h[illegible] alive on March 27 1923

and that death occurred, on the date stated above, at 12 20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes No Date of 2/10/22

Was there an autopsy?

What test confirmed diagnosis? —

3/28/23 (Signed) Thos Fa Stevens M. D

(Address) 2878 Hartford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: March 30, 1923

20-UNDERTAKER: Margaret L. Flynn — ADDRESS: 1122 Light St.

2—WRITE PLAINLY WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74238 ✓

D74238

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ninth St. Masonville ST., 75 WARD)

2-FULL NAME Rosa A. Chaney

(a) RESIDENCE NO. Masonville ST., ... WARD 25

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jos. E Chaney

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Thos. Layman

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Cockran

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Thos. J. Chaney
(Address)

15 Filed Mar 24. 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan ....., 1923, to Mch 27, 1923,
that I last saw him alive on Mch 27, 1923,
and that death occurred, on the date stated above, at 6 P. m.
THE CAUSE OF DEATH* was as follows
Carcinoma of Throat

(duration) about yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Brooks, M. D.
, 192 (Address) Chas A Brooks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	March 30 1923
20 UNDERTAKER	ADDRESS
Margaret L. Flynn	1412 Light St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mr 28 1923

Spec—12-23-21—E.B.R.S.—400 Bks.

D74239 HEALTH DEPARTMENT—CITY OF BALTIMORE D74239

CERTIFICATE OF DEATH. 21

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 2104 Lafayette ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward F. Connolly

(a) Residence No. 2104 Lafayette ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Connolly

6-DATE OF BIRTH (month, day and year) December 31 1867

7-AGE. 56 yrs. 2 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 166

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Bath

PARENTS.

10-NAME OF FATHER, Harry Connolly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Rooh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) Anna Connolly

(Address) 2104

15- Filed MAR 28 1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 27 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan. 30. 19 23 to March 27 19 23

that I last saw him alive on March 27 19 23

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) William Frouce M. D.

3/28, 1923 (Address) 1407 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loraine — DATE OF BURIAL, March 29 1923

20-UNDERTAKER Wendell Bryfogle & Son — ADDRESS 3781 Eutaw

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74240 D74240

CERTIFICATE OF DEATH

129

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 2521 W Pratt St. ST. 70 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sallie D Jones.

(Residence in Baltimore: No. 2521 W. Pratt St. 40 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: August (Month) 15 (Day), 1849 (Year)

7 AGE: 73 yrs. mos. 12 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Langmire County Virginia

PARENTS

10 NAME OF FATHER: French Ramsdall.

11 BIRTHPLACE OF FATHER (State or country): Langmire County Virginia

12 MAIDEN NAME OF MOTHER: Mary Crump.

13 BIRTHPLACE OF MOTHER (State or country): Langmire County Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lucie Riley
(Address) 2521 W Pratt St.

15 Filed ....., 191 .... Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 27 (Day), 192 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 27, 192 to March 27 192
that I saw h— alive on March 27, 192
and that death occurred, on the date stated above, at 4:30 p.m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 18 Hours yrs. mos. ds

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) 2 yrs. 3 mos. ds.

(Signed) C H Brueckner M. D.

....., 191 .... (Address) 1328 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Mar 29, 192

20 UNDERTAKER: J B Pippett — ADDRESS: 2236 Frederick Ave

AR 281923

Spoc—12-23-21—E.B.R.S.—400 Blks.

Zimmerman ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74241 D74241

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2123 E. Monument St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina D. Zimmerman

(a) Residence No. 2123 E. Monument St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, WIFE of (or HUSBAND of) Adolph Zimmerman

6-DATE OF BIRTH (month, day and year) June 2 1854

7-AGE. 69 yrs. 9 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Florist
(b) General nature of industry, business, or establishment in which employed (or employer) 886
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-
(Informant) Emma C. Krueger
(Address) 2623 E. Monument St

15-
Filed Mar 28 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-25-23

17- I HEREBY CERTIFY, That I attended deceased from 3-19-23 to 3-25-23 19..

that I last saw h.. alive on 3-25-23 19..

and that death occurred, on the date stated above, at 6.20 m.

The CAUSE OF DEATH* was as follows:

Grippe

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardium

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Bernstein M. D.

3-27-23 19.. (Address) 700 N. Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Green Mount Cem. — DATE OF BURIAL, Mar 29 1923

20-UNDERTAKER, Jas. L. Miller — ADDRESS 2334 Jefferson St

THIS IS A PERMANENT RECORD. Entry should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS should be carefully supplied. AGE should be stated instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74242
1624 Sum

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74242

CERTIFICATE OF DEATH.

X 84

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Jefford

(a) RESIDENCE NO..... ST., ... WARD Barnes Pa
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1 - ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	13	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Pa

PARENTS

10 NAME OF FATHER Fred Jeffords

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Elsie Eddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 MAR 28 1923 Robert P. Harrison, .19 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to March 28 1923 that I last saw him alive on March 28 1923, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Barnes Pa

Did an operation precede death? Yes Date of 3-27-23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Warfield M. Firor, M. D.

. 19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Sheffield Pa — DATE OF BURIAL March 30 1923

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 B Way

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... CUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Bks.

D74243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74243

CERTIFICATE OF DEATH.

6 47

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2814 Philadelphia Ave ST., WARD)

2-FULL NAME Emma J. Harwetel

(a) RESIDENCE NO. 2814 Philadelphia Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Marshall G. Harwetel

6 DATE OF BIRTH (month, day, and year) Sept. 4, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Roderick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabelle Haines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Marshall G. Harwetel

(Address) 2814 Philadelphia Ave.

15 Robert P. Harrison, Registrar

MAR 28 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922, to March 27, 1923, that I last saw h alive on 11 26, 1923, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6/20/22

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) P. O. Deaver, M. D.

3/27, 1923 (Address) 2907 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md.	Mch. 30, 1923
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway,

Spec.—1-10-21—M&T—1500 Bks.

D74244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74244

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3927 Mt. Pleasant Ave. WARD) 26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Zeiters

(a) RESIDENCE NO. 3927 Mt. Pleasant Ave WARD 26
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William H. Zeiters

6 DATE OF BIRTH (month, day, and year) Dec 18-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Callender

11 BIRTHPLACE OF FATHER (city or town) U. S.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) U. S.
(State or country)

14 Informant William H. Zeiters
(Address) 3927 Mt. Pleasant ave

15 Filed MAR 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-25, 1923, to 3-27, 1923, that I last saw h[illegible] alive on 3-26, 1923, and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion
Pulmonary Tuberculosis

(duration) 2 yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Dil Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Wilder, M. D.

3/27, 1923 (Address) 3232 Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	March 30 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	408 S. Howard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74245

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Roger Franklin Baker

(Residence in Baltimore: No. Devere Place, Catonsville, Md. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (write the word.)
male	white	single

6-DATE OF BIRTH. Sept. 26, 1903.
(Month) (Day) (Year)

7-AGE. 19 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stock broker
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country). Catonsville Md.

PARENTS.

10-NAME OF FATHER. Harry Baker

11-BIRTHPLACE OF FATHER, (State or Country). Catonsville Md.

12-MAIDEN NAME OF MOTHER. Katherine Zell

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address).....

15.

Filed MAR 29 1923 192. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27/23
(Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said: inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumothorax- thoracic & abdominal hemorrhage. (Fractured ribs both sides, rib punctured diaphragm & ruptured spleen) No fracture of skull

CONTRIBUTORY (Secondary) Automobile accident. over
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Culler M. D.
(Coroner.)

3/27/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

....., Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	March 30 1923
20-UNDERTAKER.	ADDRESS
Henry H. Perkins Son & Co	Orchard & Fremont Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

162139
D74246

HEALTH DEPARTMENT—CITY OF BALTIMORE D74246

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE (No. JOHNS HOPKINS HOSPITAL ST., 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Bocklage.

(a) RESIDENCE No. Fait Ave 139th St. Hudson Heights (City) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 20 ds. How long in U. S., if of foreign birth? 1yr. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, Dtd

(b) General nature of Industry, business, or establishment in which employed (or employer) (")

(c) Name of employer (")

9 BIRTHPLACE (city or town) (State or country) ? Md

PARENTS

10 NAME OF FATHER Theodore Bocklage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Bopler.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Record.

15 MAY 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1. 1923. to March 28. 1923. that I last saw h alive on March 27. 1923. and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos ? ds.

CONTRIBUTORY (Secondary) Generalized Tuberculosis

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL March 30, 1923.

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe St.

Spec—12-23-21—E.D.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74247

CERTIFICATE OF DEATH.

90 D74247

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 110 S Broadway St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E Lee Martin

(a) Residence No. 110 S Broadway St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 13 1864

7-AGE, 58 yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER William R Martin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Easton Md

12-MAIDEN NAME OF MOTHER, Caroline Hudson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Mrs Sallie Hudson

(Address) 110 S Broadway

15- Filed MAR 29 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 27-1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Mar 27, 1923, that I last saw h.. alive on Mar. 27, 1923, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) O/B Burton M. D.

, 19 (Address) 1711 E Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL, Mch 30 1923

20-UNDERTAKER. Chas C. Mitchell — ADDRESS 720 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74248 HEALTH DEPARTMENT—CITY OF BALTIMORE D74248

CERTIFICATE OF DEATH.

90 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4310 Bowdale St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Gary

(Residence in Baltimore: No. 4300 Bowdale St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Feb (Month) 27 (Day) 1874 (Year)

7-AGE: 49 yrs. 1 mos. ds. If LESS than 1 day, hrs. or mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Louis Harrington

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Rosa Pambant

13-BIRTHPLACE OF MOTHER, (State or Country): Petersburg Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin A. Cain

(Address) 1432 So Spring dale ave

15- MAR 29 1923

ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart & Kidneys

(Duration) yrs. mos. 1 hrs.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo E. C. Radcliffe M. D.

(Coroner)

1923 (Address) 423 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cem

DATE OF BURIAL: Mch 29 1923

20-UNDERTAKER: John C. Mitchell

ADDRESS: 201 W Fayette St

Spec.—1-10-21—M&T—1500 Bks.

Hoffman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74249

CERTIFICATE OF DEATH.

148 D74249

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Muriel Hoffman

(a) RESIDENCE NO. 1706 N Rat Rock ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? / yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Irving H. Hofmann

6 DATE OF BIRTH (month, day, and year) June 29 99

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ansonia Conn

PARENTS

10 NAME OF FATHER Wm F. Blythe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Irene M.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant Herman Hofmann

(Address) 1206 N. Rat Rock

15 Filed MAR 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922 to March 27, 1923.

that I last saw h alive on March 27, 1923,

and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) ... yrs. 8 mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) R. E. Pearson, M. D.

May 29, 1923 (Address) 301 N Rat Rock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Conn.

DATE OF BURIAL 3/30 1923

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74250 HEALTH DEPARTMENT—CITY OF BALTIMORE

88 D74250

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Jacob Foland ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Foland

(a) RESIDENCE NO. 1614 E. Monument ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Foland

6 DATE OF BIRTH (month, day, and year) Feb 16 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Foland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1439 E. Baltimore

15 Filed MAR 29 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 14 1923 to Mch 28 1923.

that I last saw him alive on Mch 28 1923

and that death occurred, on the date stated above, at 7.55 P m.

The CAUSE OF DEATH* was as follows: Subacute Bacterial Endocarditis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1614 E. Monument St

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Leonard Greenbaum M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	3-29-1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Balto. St.

Spec.—1-10-21—M&T—1500 Bks.

D74251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74251

CERTIFICATE OF DEATH.

23

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2524 Brookfield Ave ST., 13 WARD)

2-FULL NAME Morris Romhro

(a) RESIDENCE NO 2524 Brookfield ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 28 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mollie Romhro

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mfg Merchant Shirt

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balt St

15 Filed MAR 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 11, 1923, to March 27, 1923, that I last saw him alive on March 27, 1923, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Encephalitis Epidemica

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Paralysis of respiratory Centre (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger M. D.

(Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	3/29 1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74252

D74252

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Carroll ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest P. Comer

(a) RESIDENCE. NO. 1416 Carroll ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug. 11-22

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
7 month	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER James and Comer

11 BIRTHPLACE OF FATHER (city or town) Elbridge (State or country) Ind

12 MAIDEN NAME OF MOTHER Sophia Johnson

13 BIRTHPLACE OF MOTHER (city or town) Elbridge (State or country) Ind

14 Informant Mrs Sophia Comer. (Address) 1416 Carroll st

15 Filed MAR 29 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 21, 1923, to Mar 26, 1923, that I last saw h in alive on Mar 26, 1923, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Stanley Stoag, M. D.

3/27 1923 (Address) 29 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elbridge Ind

DATE OF BURIAL 3/29/23

UNDERTAKER Geo W Hooper & Son

ADDRESS W. Camden st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

Spec.—6-[illegible] H. P. Co.—1000 Bks.

D74253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74253

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2067 W Biddle St ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Peter Perry

(a) RESIDENCE. NO. 2067 W Biddle St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873 March 7 day unknown

7 AGE	50 Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer by self

9 BIRTHPLACE (city or town) Jacksonville Fla
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) Texas

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Texas
(State or country)

14 Informant H. Broderick
(Address) 703 W Lafayette

15 Filed MAR 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Mar 24, 1923, that I last saw h[illegible] alive on Mar 24, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of heart

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Broderick, M. D.

3-27 1923 (Address) 703 W Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Mar 29 1923
20 UNDERTAKER	ADDRESS 1140 W.
Brown & Leeland	Belvedere st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74254

CERTIFICATE OF DEATH.

91-00

D74254

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gneral Hosp ST., 17 WARD)

2-FULL NAME Joseph D. White

(a) RESIDENCE NO. 1105 Penn Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie White

6 DATE OF BIRTH (month, day, and year) Aug. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	8	Unknown	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Griffith White

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Rachael Bacock

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Andrew M Wilmot
(Address) 1811 W Lanvale St

15 Filed ....., 19 ROBERT H. KRAUTER, Registrar
MAR 29 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-10, 1923, to 3-28, 1923, that I last saw him alive on 3-28, 1923, and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Chas Wilbur Stewart, M. D.

3/28, 1923 (Address) 1738 E. 28th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Mar 30, 23

20 UNDERTAKER Wm J. McInerney & Sons — ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74255

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Doyle

(a) RESIDENCE NO. Hillsdale, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not given

6 DATE OF BIRTH (month, day, and year): 1871 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Michael Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Alice Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Records

(Address): M.T.H.

15 MAR 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to March 28, 1923, that I last saw him alive on March 28, 1923, and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Moist gangrene of leg.

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dodgheaded M. D.

3-28-23

(Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Romanus Cem

DATE OF BURIAL: 3-30 1923

20 UNDERTAKER: James. Dignan's Sons

ADDRESS: 8 Pass St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74256

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

101-001

D74256

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Ashland. ave ST., 10 WARD)

2-FULL NAME Mary J. Doerfler

(a) RESIDENCE NO. 1469 Ashland av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter J. Doerfler

6 DATE OF BIRTH (month, day, and year) October 21 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Diehl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Clara Poehlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Peter J. Doerfler
(Address) 1409 Ashland av

15 Filed MAR 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1 1923 to March 29 1923,

that I last saw h alive on March 27th 1923

and that death occurred, on the date stated above, at 3 25 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 20 ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. R. Stone, M. D.

March 29 1923 (Address) 1301 E Eager st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 2 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager st

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74257

159-007

CERTIFICATE OF DEATH.

D74257

REGISTERED NO.

1-PLACE OF DEATH St Vincent's Infant Asy.

CITY OF BALTIMORE: (No. 1401 Division St ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Mullaney.

(a) RESIDENCE NO. 1401 Division St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of Industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) Balto, Md
(State or country)

PARENTS

10 NAME OF FATHER Thos Mullaney.

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) not known

12 MAIDEN NAME OF MOTHER Rose Moran.

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country)

14 Informant St Vincent Inft Asylum
(Address)

15 MAR 29 1923 Filed, 19 .... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25-1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to March 25, 1923, that I last saw h[illegible] alive on March 25, 1923, and that death occurred, on the date stated above, at 6 PM m.

The CAUSE OF DEATH* was as follows:

Asphyxiation
(accidental)

.... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
.... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? .... Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) Chas R. Goldborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL March 29 1923

20 UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS — ADDRESS 1936 W. PRATT STREET.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital Heart Defect

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D74258

CERTIFICATE OF DEATH.

D74258

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Wigglesworth

(a) Residence No. 1115 Jordan St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1852 ?

7-AGE. 70 ? yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS

10-NAME OF FATHER, William Wigglesworth

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 29 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 25, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 19, 1923 to March 25, 1923 that I last saw him alive on March 25, 1923 and that death occurred, on the date stated above, at 12:40 P. M.

The CAUSE OF DEATH* was as follows:

appleexy

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) atherosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. McCoy M. D.

3-26-, 1923 [Address] Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL. 19....

20-UNDERTAKER, Commissioner Health, ADDRESS MAR 29 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

106

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74259

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D74259

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2878 Woodbrook Ave St.; 15 WARD)

2-FULL NAME James Wright Moffett

(Residence in Baltimore: No. 2878 Woodbrook Ave St.; life yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Feb. 22, 1865 (Month) (Day) (Year)

7-AGE: 58 yrs. 1 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Chauffeur 086
(b) General nature of industry, business, or establishment in which employed (or employer): National Oil Co

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Jesse Moffett

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Rosie Storey

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha P. Moffett

(Address) 2878 Woodbrook Ave

15-MAR 29 1923 Filed ....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March 27, 1923 (Month) (Day), (Year)

17-I HEREBY CERTIFY, That I attended deceased from March 15, 1923, to March 27, 1923

that I saw h[illegible] alive on March 27, 1923

and that death occurred, on the date stated above, at 10.20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Embolism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Belmont Taylor M. D.

March 27, 1923 (Address) 2731 Barkwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore County

DATE OF BURIAL: March 30, 1923

20-UNDERTAKER: Jos. A. Syfert

ADDRESS: 1600 N. Paca St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74260

CERTIFICATE OF DEATH.

100-001

D74260

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital, St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Disney

(a) Residence No. 120 S. Patterson Park Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1840

7-AGE. 82 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Sam Disney

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Elizabeth Heberit

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country).

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 29 1923 192 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 22, 19 23 to March 27 19 23

that I last saw h.er alive on March 26, 19 23

and that death occurred, on the date stated above, at 4:50 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) 3 yrs. mns. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mns. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McCrea M. D.

3-27-, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem.	March 29, 1923
20-UNDERTAKER.	ADDRESS
Mrs Albert E. Fuller	Harford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74261

100-001 D74261

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Harlem ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L Hogg

(Residence in Baltimore: No. 1110 Harlem ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 2 (Day), 1850 (Year)

7-AGE, 72 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Co Md

PARENTS.

10-NAME OF FATHER, Nelson Forsuch

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie L Hogg

(Address) 1110 Harlem Ave

15- Filed MAR 29 1923, 191..... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 28th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 21 1923, to Mar 28 1923, that I saw h.. alive on Mar 28 1923, and that death occurred, on the date stated above, at 2:12 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Patent Foramen Ovale

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Edward C Hurst M. D.

3-29, 191.. (Address) 102 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	March 30, 1923
20-UNDERTAKER George J Smith	ADDRESS 1532 Hollins st

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1625-38 Md D74262

CERTIFICATE OF DEATH. X 101-001 D74262

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. 1 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Talbert

(a) RESIDENCE NO. Ecleston Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 days yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Orphy Talbert

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse Talbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed MAR 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25. 1923. to March 27. 1923.

that I last saw h— alive on March 27. 1923. 4 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture + Physical Examination

(Signed) E. Coutts Andrus, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampstead Cemetery — DATE OF BURIAL Mar 30 1923

20 UNDERTAKER J. F. Elsine — ADDRESS Reisterstown Md

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74263

CERTIFICATE OF DEATH.

11-00

D74263

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 Jasper St ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Gross

(a) RESIDENCE. No. 632 Jasper ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 1899

7 AGE — Years: 24 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitress

(b) General nature of industry, business, or establishment in which employed (or employer): O'Donnells

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Alexander Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lucy Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Lucy Gross 632 Jasper St

15 Filed MAR 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 27 1923

17

I HEREBY CERTIFY, That I attended deceased from July 26, 1923, to Mar 27, 1923

that I last saw her alive on Mar 27, 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ac. Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Frank E. Naphin M. D.

Mar 27 1923 (Address) 1506 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
H Lutheran	3/30 1923

20 UNDERTAKER: Samuel J Hamilton ADDRESS 578 Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Influenza

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74264

CERTIFICATE OF DEATH.

74-002 D74264

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 178 Richmond ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jennings

(a) RESIDENCE NO. 178 Richmond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Jennings

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Home 041

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Dudley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Lenin Jennings 178 Richmond St

15 MAR 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/22, 1923, to 3/27, 1923, that I last saw h[illegible] alive on March 27, 1923, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Acetone Chloroses

(duration) yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary) Hardening of the arteries

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Md

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Clisc, M. D.

, 19 (Address) 524 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 3/29 1923

20 UNDERTAKER Clarence E. Dudley

ADDRESS 1711 E. Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D74265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74265

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1723 Baker St.) WARD) 15 '02

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Howard L. Kelley,

(Residence in Baltimore: No. 1723 Baker St. St.: yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	Single

6-DATE OF BIRTH, about July (Month) ..., 1914 (Day) (Year)

7-AGE, ...yrs. 8 ...mos. ...ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Roland Kelley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Maggie Barnes

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Kelley

(Address) 1723 Baker St

15-

Filed MAY 29 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation of neck, accidental

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Caught foot between wheels of moving cars.

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

March 28, 1923. (Address) 2 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, May 29, 1923

20-UNDERTAKER Jos. M. Johnson

ADDRESS 1234 Ething St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Blks.

D74266

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-60

D74266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. John Hafayette ST. 77 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Isaac.

(a) RESIDENCE NO. 655 Washington Blvd. (Father) ST., ... WARD .....

(Usual place of abode) (Ii non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1½ ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	✓

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 28 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	1½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of industry, business, or establishment in which employed (or employer) ..... ood

(c) Name of employer —

9 BIRTHPLACE (city or town) Woman's Hospital Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Rev. Frank R. Isaac Jr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Marjorie A. Baker

13 BIRTHPLACE OF MOTHER (city or town) Chicago Ill.
(State or country)

14 Informant Father 655 Washington Blvd.
(Address)

MAR 29 1923 Robert P. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 29 1923

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1923, to March 29, 1923.

that I last saw him alive on March 29, 1923,

and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Premature.

Malnutrition - Infarcted Placenta.

(duration) 0 yrs. 0 mos. 1½ ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Catherine Porter, M. D.

, 19 (Address) Woman's Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL Mar 30 1923

20 UNDERTAKER Wm J. Tickner & Sons

ADDRESS North Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74267 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74267

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 1448 Homestead St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... August C. Reinhardt

(a) Residence No..... 1448 Homestead St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds How long in U. S., if of foreign birth 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lucretia Reinhardt

6-DATE OF BIRTH (month, day and year) August 1852

7-AGE, 70 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Otis

(b) General nature of industry, business, or establishment in which employed (or employer) Same Owner

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, John Reinhardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Andrews

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Mrs. Lucretia Reinhardt

(Address) 1448 Homestead

15- Robert P. Harrison, Registrar.

MAR 29 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 26 1923

17- I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to March 26, 1923.

that I last saw h.. alive on March 24, 1923.

and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter D. Cornwell M. D.

3/28, 1923 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodmans Lot DATE OF BURIAL, March 29 1923

20-UNDERTAKER, Wilhelm Bros & Martin ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Entries should be made instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(French) Se Francis 1302 W. Lombard

D74268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74268

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 1517 E. North Ave St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catharine E. French

(a) Residence No. 1517 E North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mch 27 1842

7-AGE, 81 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14- (Informant) Alexander F. French

(Address) 517 E North Ave

15- Robert P. Harrison, Registrar.

MAR 29 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mch 27 1923

17- I HEREBY CERTIFY, That I attended deceased from 3/4/23, 19..., to 3/27/23, 19..., that I last saw h.. alive on 3/24/23, 19..., and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

Old age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (cerebral)

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Harrison M. D.

3/28, 19 (Address) 1302 Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Mch 31, 1923

DATE OF BURIAL,

20-UNDERTAKER, Wm Cook

ADDRESS 001 E North Ave

Certified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D74269

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D74269

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registered No.

2-FULL NAME Edward J. Barnes

(a) Residence No. 1519 McCullough St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Barnes

6-DATE OF BIRTH (month, day and year) Nov 1, 1872

7-AGE. 51 yrs. 4 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Bldg

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS

10-NAME OF FATHER, Charles Barnes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Virginia D. Shield

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) E. M. Chapman

(Address) 949 Madison

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 29 1923

17- I HEREBY CERTIFY, That I attended deceased from March 6, 1923 to March 29, 1923

That I last saw h.. alive on March 29, 1923

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Uremia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym & Signs

(Signed) J. J. Savage M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem DATE OF BURIAL. 3/31 1923

20-UNDERTAKER Wm Cook ADDRESS 502 E North

29

Should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION is very important. Write in plain terms, so that it may be properly classified. See instructions on back of certificates.

D74270 HEALTH DEPARTMENT—CITY OF BALTIMORE D74270

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Station St. 15 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Rieker Leeser

(Residence in Baltimore: No. 2905 Ullman St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE. 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Moses Kohn

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morris Leeser

(Address) 2905 Ullman

15- MAR 29 1923 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart, 2 minutes (Duration) Hrs. Days mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

Mar 29 1923 (Address) 1637 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death [illegible] mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Harsimus Cemetery DATE OF BURIAL, March 30 1923

20-UNDERTAKER, J. Ahrens & Co ADDRESS 1611 Madison Ave

R 29 1923

If state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74271

CERTIFICATE OF DEATH.

D74271

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel H. Rosenau

(a) RESIDENCE NO. 1515 Eutaw Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William Rosenau

6 DATE OF BIRTH (month, day, and year) Jany. 13 1875

7 AGE	Years	Months	Days
	48	2	16

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Omaha (State or country) Neb.

PARENTS

10 NAME OF FATHER Myer Hellman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Rau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Robert P. Harrison, Burial Permit Clerk Registrar

3 29 1923 . 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29/ 1923.

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to March 29, 1923, that I last saw her alive on March 29, 1923, and that death occurred, on the date stated above, at 12.40 a.m.

The CAUSE OF DEATH* was as follows:

brain tumor
(pontile-angle right)
(sarcoma)

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of March 28. 23

Was there an autopsy? No.

What test confirmed diagnosis? operation.

(Signed) Cecil H Bagley, M. D.

. 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom

DATE OF BURIAL 3/30/ 1923

20 UNDERTAKER David Sondheim

ADDRESS 115-20 W. Mt. Royal Ave.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

D74272 HEALTH DEPARTMENT—CITY OF BALTIMORE D74272

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. St. Joseph Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Sherry

(Residence in Baltimore: No. 402 E. Preston St.; yrs. 27 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (write the word.)
male	white	single

6-DATE OF BIRTH, unknown (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Night watchman
(b) General nature of industry, business, or establishment in which employed (or employer): M & M Nat. Bank 162

9-BIRTHPLACE, (State or Country). Ireland

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. P. Kehoe

(Address) 508 Orkney Rd. Govans

15- Robert P. Harrison,

MAR 29 1923 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Pneumonia 4 days dur.
following fractured ribs rt. side
Fr. RT. Tibia & fibula, fr. rt humer

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by Auto. Mar. 14

Investigation to be held later (Duration) yrs. mos. ds.

(Signed) J. S. H. Collins M. D.
(Coroner.)

3/27/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral DATE OF BURIAL, March 30 1923

20-UNDERTAKER, E. A. Wedefeld ADDRESS 501 E 22

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74273

D74273

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2746 W Balto St., 20 WARD)

2-FULL NAME Louisa Heisler

(a) RESIDENCE NO. 2746 W Balto ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christian Heisler

6 DATE OF BIRTH (month, day, and year): 9-25-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm Selea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs J E Webb
(Address): 2746 W Balto St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MAR 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 28, 1923, that I last saw h alive on March 27, 1923, and that death occurred, on the date stated above, at 4 02 2 m.

The CAUSE OF DEATH* was as follows:

Intestinal Uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Geary, M. D.

, 19 (Address) 101 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem

DATE OF BURIAL: Mar 30 1923

20 UNDERTAKER: John Ullrich

ADDRESS: 2008 Aliceanna

mation should be carefully supplied. AGE should be stated EXACTLY; FRACTIONS may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

D74274 HEALTH DEPARTMENT—CITY OF BALTIMORE D74274

CERTIFICATE OF DEATH. 100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 520 N. Saratoga St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carlett Hall

(Residence in Baltimore: No. 520 N. Saratoga St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

DATE OF BIRTH: June (Month) 25 (Day) 1923 (Year)

7-AGE: ....yrs. 2 mos. ....ds. If LESS than 1 day, ...hrs. or.... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: C
(b) General nature of industry, business, or establishment in which employed (or employer): 800

9-BIRTHPLACE (State or Country): Balto City

PARENTS:
10-NAME OF FATHER: Harry Hall
11-BIRTHPLACE OF FATHER (State or Country): Md
12-MAIDEN NAME OF MOTHER: Mrs. Dodger
13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Hall

(Address) 520 Saratoga St

15- MAR 28 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ...her... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cold

(Duration) yrs. mos. ds.

(Signed) H K Forrsmal M. D. (Coroner.)

3-27-1923 (Address) 117 N. Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem DATE OF BURIAL: 3-30, 1923

20-UNDERTAKER: Geo. E. A. Gibson ADDRESS: 613 Fawn St

If state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74275

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D74275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1218 Hollins ST.: 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mario M. G. Allen

(Residence in Baltimore: No. 1218 Hollins St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 30 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Hiram Allen

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Mary Ann Motley

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Allen

(Address) 1218 Hollins St.

15- Robert P. Harrison,

MAR 29 1923 ....., 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Cerebral Paresis .....

.....

.....

..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Benton M. D.
(Coroner.)

Mar. 29. 1923 (Address) 704 Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Batavia N. Y. DATE OF BURIAL, March 28 1923

20-UNDERTAKER John O. Mitchell ADDRESS 1201 N. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74276 HEALTH DEPARTMENT—CITY OF BALTIMORE D74276

CERTIFICATE OF DEATH. 90 Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Ramsay & Jones St. 21 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Conrad Fox

(Residence in Baltimore: No. 1120 Washington Blvd St.; yrs. 75 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Widower

6-DATE OF BIRTH. March 26 1848
(Month) (Day) (Year)

7-AGE. 75 yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Laborer

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.
10-NAME OF FATHER. Daniel Fox
11-BIRTHPLACE OF FATHER, (State or Country). Germany
12-MAIDEN NAME OF MOTHER. Julia
13-BIRTHPLACH OF MOTHER, (State or Country). Germania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John H Fox
(Address) 1120 Washington Boulevard

15-
29 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D.
(Coroner)
Mar 29 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cem DATE OF BURIAL. Mar 31st 1923

20-UNDERTAKER. Mrs Mr John W Ferfle ADDRESS 801 W Fayette

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60-002 D74277

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division St. ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. ~~Aaron~~ Sara Bliveis (Dora)

(a) RESIDENCE NO. 3421 Reisterstown Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Bliveis

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Paul Goldberg

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Sylvia Oshonsky

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Aaron Bliveis (Address) 3421 Reisterstown Road.

15 Filed MAR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to March 29, 1923, that I last saw h-V alive on March 29, 1923, and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Toxic goitre c psychoneurosis

about (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation, c partial thrombosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 27, 23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B Jones, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodelph — DATE OF BURIAL 3/30 1931

20 UNDERTAKER Jack Lewis — ADDRESS 1409 E Baltimore

mation should be carefully supplied. AGE should be given for the last birthday. Exact statement of OCCUPATION should be made. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Bornstein

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74278

CERTIFICATE OF DEATH.

57 D74278

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital & Asylum

CITY OF BALTIMORE: (NO. ... ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Laura Bornstein

(a) RESIDENCE NO. 31 N. Anna ST., Balto Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Bornstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 48 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Moses Feldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Host

15 Filed MAR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to March 29, 1923, that I last saw h[illegible] alive on 3/29/23, 19..; and that death occurred, on the date stated above, at 4:10 p.m.

The CAUSE OF DEATH* was as follows: Cardiac Failure

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Decubitus ulcer Lumbar (duration) ... yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

, 19 (Address) Hebrew Hospital & A.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery

DATE OF BURIAL 3/30 1923

20 UNDERTAKER Jack Levin

ADDRESS 1434 E Balto St

BEFORE SHOULD BE STATED (1) THE DISEASE CAUSING DEATH, or in deaths from violent causes the MEANS AND NATURE OF INJURY, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74279 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D74279

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Schaikin

(Residence in Baltimore: No. 531 N. Washington St.; yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
male	white	single

6-DATE OF BIRTH. March 29/1013 (Month) (Day) (Year)

7-AGE. 9 yrs. 11 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Isaac Schaikin

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Lena Karosik

13-BIRTHPLACE OF MOTHER. (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Schaikin

(Address) 531 N. Washington St.

15- FILED MAR 30 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28/1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Acute Encephalitis

(Autopsy refused)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Scarlitina or encephalitis lethargica (Duration) yrs. mos. ds.

(Signed) Jos. H. Collins M. D. (Coroner.)

3/29/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Workmen circle Cem. DATE OF BURIAL. 3/30 1923

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74280

CERTIFICATE OF DEATH.

44 D74280

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Oakland Ave. Govans, Md. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Brown Thatcher

(a) RESIDENCE NO. 507 Oakland Ave. Govans, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter C. Thatcher

6 DATE OF BIRTH (month, day, and year) June 29" 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Elijah Brown

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Barton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Walter C. Thatcher (Address) 507 Oakland Ave.

15 MAR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 28" 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Mch 28, 1923, that I last saw h[er] alive on Mch 28, 1923, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(duration) about 6 mos.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Tumor, Clinical history & B.I.T.

(Signed) Jno A Luetcher M. D.

(Address) 1025 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL March 31 1923

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Chas St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D74281

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 Warner ST., 21 WARD)

2-FULL NAME John P. Parran

(a) RESIDENCE NO. 934 Warner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Parran

6 DATE OF BIRTH (month, day, and year) unknown 1871

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 940

(b) General nature of industry, business, or establishment in which employed (or employer) Obrio Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. md

PARENTS

10 NAME OF FATHER Major Parran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucresa Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mattie Parran (Address) 934 Warner St.

15 Filed MAR 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23. 1923. to March 28. 1923.

that I last saw h-alive on March 28, 19...

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) D N Hirsch, M.D.

(Address) 712 C Mary Ln.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 3-30-23

20 UNDERTAKER Jno. H. Toadvine — ADDRESS 142 W. Hill St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74282

CERTIFICATE OF DEATH.

101-001

D74282

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Gray

(a) RESIDENCE NO. 1414 Druid Hill Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-16-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Odd

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Bessie Gallice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Bessie Gray (Address) 1414 Druid Hill Ave

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 23

17

I HEREBY CERTIFY, That I attended deceased from March 26, 19 23 to March 28, 19 23, that I last saw h[im] alive on March 28, 19 23, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia

Duration - 7 ds.

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Nephritis Chr.

(duration) ..... yrs. ..... mos. 10? ds.

18 Where was disease contracted if not at place of death? 1414 Druid Hill Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. B. Hunter, M. D.

(Address) March 28, 1923 1413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	March 30, 23
20 UNDERTAKER	ADDRESS
John H. Goodwin	1424 Hill St

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74283

CERTIFICATE OF DEATH.

101-001

D74283

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N Howard ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Hopkins

(a) RESIDENCE. NO. 811 N Howard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Executive 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER James B Hopkins

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Emil Hopkins
(Address) Stevensville Md

15 FILED MAR 30 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 1923, to Mar 29, 1923, that I last saw him alive on Mar 28, 1923, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 18 ds.

CONTRIBUTORY X
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) V Van Williams, M. D.

19 (Address) 601 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stevensville Md	March 30 1923
20 UNDERTAKER	ADDRESS
W M Routson	2235 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74284

CERTIFICATE OF DEATH.

100-001

D74284

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) St Agnes Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Quarles Jr.

(a) RESIDENCE NO. 1411 E Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Child

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): April 16 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Quarles Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Thomas Quarles Sr

(Address) 1411 E Pratt st

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 29 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1923, to Mar. 29, 1923, that I last saw him alive on Mar. 29, 1923, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

Dyed

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edward A. Kotlowski, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden

DATE OF BURIAL: March 30, 23

20 UNDERTAKER: Chenowith & Son

ADDRESS: Chestertown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

J

D74285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74285

CERTIFICATE OF DEATH.

22 X 90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 211 W. Montgomery St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Levi Topin. (C).

(Residence in Baltimore: No. 211 W. Montgomery St. St.; yrs. ------ mos. 8 ds. ------)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Widower.

6-DATE OF BIRTH. Do not know. 1..... (Month) (Day) (Year)

7-AGE. 80 yrs. -- mos. --- ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Emma Jackson. (C) (granddaughter).
(Informant).....
211 W. Montgomery St.
(Address).....

15- Filed MAR 30 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart & kidneys.

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Mar. 25, 1923. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Cemetery DATE OF BURIAL. Mar. 30 1923

20-UNDERTAKER. James H. Dennis ADDRESS, 312 Druid Hill Ave.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Rks.

162524 HEALTH DEPARTMENT—CITY OF BALTIMORE 59-002 D74286

11 D74286

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Williams.

(a) RESIDENCE No. 1817 E. Madison St. City Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of (or) WIFE of~~ (—)

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years (—) Months 3. Days (—)

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer) (—)

(c) Name of employer (—)

9 BIRTHPLACE (city or town) (State or country) ? ?

PARENTS

10 NAME OF FATHER William Shaw.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Ethel Williams.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 25. 1923. to March 28. 1923.

that I last saw him alive on March 28. 1923

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of heart

(duration) yrs. Life mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lowndes Cemetery — DATE OF BURIAL: Mar 30 1923

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 924 Eastlander

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74287 44 D74287

PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tobias Baker

(a) RESIDENCE No. 2309 Mendawmin Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Baker

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing merchants

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ephrain Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fanna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1434 E. Baltimore

15 MAR 30 1923 ROBERT R. KRAUTH Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30- 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-21- , 1923, to 3-30- , 1923, that I last saw him alive on 3-30- , 1923, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 3-23-23

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. B. Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cemetery DATE OF BURIAL 3/31/23

20 UNDERTAKER Jack Lewis 1439 E Baltimore ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74288

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH 1416 E. Chase pl

CITY OF BALTIMORE: (No. 1416 E. Chase ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albertina Harrison

(a) RESIDENCE. No. 1416 E. Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Harrison

6 DATE OF BIRTH (month, day, and year): Autumn

7 AGE: Years 59; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Samuel Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E. Baltimore

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-20 1923

17 I HEREBY CERTIFY, That I attended deceased from March 13. 1923. to March 28. 1923

that I last saw h.r alive on March 28. 1923.

and that death occurred, on the date stated above, at 5. AM. p.m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein, M. D.

3/30. 1923 (Address) 733 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — DATE OF BURIAL: 3/30/23

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74289

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D74289

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1020 W.Cross St. 21 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary A.E.Saffield

(Residence in Baltimore: No. 1020 W.Cross St. St.; 72 yrs. 7 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	~~Widowed~~ Married

6 DATE OF BIRTH: August (Month) 23 (Day), 1850 (Year)

7 AGE: 72 yrs. 7 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm.B.Stevens

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Salgues

13 BIRTHPLACE OF MOTHER (State or country): West Indies

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard T.Saffield

(Address) 1020 W.Cross St.

15 MAR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 28 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1923, to. Mar 28, 1923, that I saw h[illegible] alive on Mar. 27, 1923, and that death occurred, on the date stated above, at 11.15A.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 6 yrs. 6 mos. ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 4 yrs. mos. ds.

(Signed), [illegible] M. D.

3/30, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: April 2, 1923

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

N. B.-Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Baltimore, Md., April 27, 1923.

I do hereby make oath that the following corredtion should be made on Baltimore City Department of Health Death Certificate D-74289.

The statement that Mary A. E. Saffield, deceased, was Widowed in in error, should be, Married.

John F. Denny
Undertaker.

Subscribed and sworn to before me this 27th day of April, 1923.

Reed Gaither.
Notary Public.

D74290

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 D74290

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2659 Lehman St. ST.: 30 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2 FULL NAME Benjamin Columbus Young

(Residence in Baltimore: No. 2659 Lehman St. St.: 63 yrs. 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: December 5, 1859 (Month) (Day) (Year)

7 AGE: 63 yrs. 3 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Remus Young

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (State or country): Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Remus Harry Young

(Address) 2659 Lehman St.

15 Filed MAR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 28 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Mar 28 1923, that I saw h[illegible] alive on Mar 28, 191, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephri[illegible]

Interstate (Duration) yrs. mos. ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. ds.

(Signed) R. L. Campbell M. D.

Mar 29, 1923 (Address) 644 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: Mar 31, 1923

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74291

CERTIFICATE OF DEATH.

48 D74291

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 104 W. Lee St ST., 27 WARD)

2-FULL NAME Hugh Edward Fagen

(a) RESIDENCE NO. 104 W. Lee St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma Fagen

6 DATE OF BIRTH (month, day, and year) Mar. 1, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	90	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Commission

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Emma Fagen (Address) 104 W. Lee St

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 – 1922 to March 28. 1923.

that I last saw him alive on March 27. 1923.

and that death occurred, on the date stated above, at 1.35 A.m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Throat + Gangrene

Carcinoma of Head + Throat (duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Head and Throat Gangrene (duration) ... yrs. 6 mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. G. W. Kennard M. D.

3-28 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Mar 31 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

TION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

12-001 V

D74292

CERTIFICATE OF DEATH.

D74292 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Day

(a) Residence No. 1112 W. Lombard St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1850

7-AGE. 72 yrs. mos. ds. If LESS than 1 day hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Case Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Nichols Day

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto., Md.

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md.

11- (Informant) Municipal Hospital Records

(Address)

13- Filed MAR 30 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 24 19 23 to March 28 19 23

that I last saw h. im alive on March 28 19 23

and that death occurred, on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic alcoholism

(Duration) 40 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. A. McCoy M. D.

3-29-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. Mar 30 1923

20-UNDERTAKER. John S. Fields

ADDRESS 1203 W Lombard st

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Clifton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74293

CERTIFICATE OF DEATH.

100-001

D74293

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2330 Druid Hill Av ST. 13 WARD)

2-FULL NAME Olan H. Clifton

(a) RESIDENCE NO. 2330 Druid Hill Av ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. — ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 12-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Charles H Clifton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md

12 MAIDEN NAME OF MOTHER Emma A Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Freedom Pa

14 Informant Chas H. Clifton

(Address) 2330 Druid Hill Ave

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/ 1923

17

I HEREBY CERTIFY, That I attended deceased from 3-27-1923, to 3-30-1923, that I last saw him alive on 3-29-1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) acute bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? ~~Typh~~ None

(Signed) Maurice L. Shamon M. D.

3/30, 1923 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Pa — DATE OF BURIAL Mar 30 1923

20 UNDERTAKER A S Marshall — ADDRESS 3539 Fall Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74294

CERTIFICATE OF DEATH.

D74294

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 Stockton ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Brown

(a) RESIDENCE. No. 1144 Stockton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marjorie C Brown

6 DATE OF BIRTH (month, day, and year) 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	+		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Oil Compounding

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mottu-Lubricating Co

9 BIRTHPLACE (city or town) Baltimore Co Md.
(State or country)

PARENTS

10 NAME OF FATHER Pitt Brown

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co. Md
(State or country)

12 MAIDEN NAME OF MOTHER Arretta Brown

13 BIRTHPLACE OF MOTHER (city or town) Snow Hill Md
(State or country)

14 Informant Marjorie Brown
(Address) 1144 N. Stockton St

15 Filed MAR 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923 to March 27, 1923, that I last saw him alive on March 26, 1923, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma
Convulsions (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1144 Stockton St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wilbur A Wright M. D.

March 27, 1923 (Address) 1207 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	30 1923
20 UNDERTAKER	ADDRESS
Samuel Hensley	Middle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MA 1 1500 Blks.

D74295 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74295

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Finesinger

(a) RESIDENCE NO. 847 Montford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1499 E. Baltimore St.

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17

I HEREBY CERTIFY, That I attended deceased from March 25, 1923, to March 30, 1923,

that I last saw h alive on March 30, 1923,

and that death occurred, on the date stated above, at 7-40 A.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs mos /ds.

CONTRIBUTORY (Secondary) Chron. Myocarditis, Arteriosclerosis

(duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Moses Gellerman, M. D.

March 30, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel Rd. DATE OF BURIAL 3/30/23

20 UNDERTAKER Jack Lewis ADDRESS 1499 E Balto

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D74296

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Pruthneowska Pruchniewska

(a) Residence No. 2421 Faith Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1901

7-AGE, 21 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Joseph Lukaszewic

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Municipal Hospital Record

(Address)

15- Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MAR 30 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 18, 1923 to March 28, 1923

that I last saw h.. or alive on March 28 1923,

and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. McKay M. D.

3-29-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross	April 1, 1923
20-UNDERTAKER	ADDRESS
Wendell Dysell & Son	37 S. Pine

In plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74297 HEALTH DEPARTMENT—CITY OF BALTIMORE D74297

CERTIFICATE OF DEATH.

21 91-002

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 710 W. Hamburg St., 21 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Andrew Baesler

(a) Residence No. 710 W. Hamburg St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE, 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cigar maker
(b) General nature of industry, business, or establishment in which employed (or employer): 017
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS

10-NAME OF FATHER. Mathew Baesler

11-BIRTHPLACE OF FATHER (city or town) (State or Country). [illegible]

12-MAIDEN NAME OF MOTHER. Barbara D Simmons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-
(Informant) Louise C. Hofmann
(Address) 710 W. Hamburg st

15-Filed MAR 30 1923 192. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/27/23

17- I HEREBY CERTIFY, That I attended deceased from March 15, 1923 to March 27, 1923, that I last saw h~~im~~ alive on March 27, 1923, and that death occurred, on the date stated above, at 7 05 p.m.

The CAUSE OF DEATH* was as follows:

Asterio - Sclerosis
Immediate Debility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. J. Kurz M. D

3-29, 1923 (Address) 801 N. Entaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem — DATE OF BURIAL. 3-30 1923

20-UNDERTAKER. ROBERT BROOKS & SON — ADDRESS Calhoun & Hollins

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74298

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 D74298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Chaney

(a) RESIDENCE NO. 608 S. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk B&O

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James S. Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Grauch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Annie Bryan

(Address) 608 S. Fulton Ave

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/24, 1923, to 3/29, 1923, that I last saw him alive on 3/29, 1923, and that death occurred, on the date stated above, at 11 25 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Leon Fordon M.D. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	4-2 1923
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun Hollins st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74299

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 Harris ST., 1 WARD)

2-FULL NAME Barbara Ermer

(a) RESIDENCE NO. 917 S. Harris ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (City or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant H. Ermer
(Address) 917 Harris

15 MAR 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to March 29, 1923,
that I last saw h[illegible] alive on March 28, 1923,
and that death occurred, on the date stated above, at 12:15 a m.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (duration) ..... yrs. Unknown

CONTRIBUTORY (Secondary) ~

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) Francis James Postl M.D.

3/24 1923 (Address) 2431 East

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity — DATE OF BURIAL Mar 30 1923

20 UNDERTAKER William Fairservice — ADDRESS 1618 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Linroth

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74300

CERTIFICATE OF DEATH.

179

D74300

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Linroth

(a) RESIDENCE NO. 2001 E. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs. Anna Linroth

6 DATE OF BIRTH (month, day, and year) Jan. 10th, 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 180

(b) General nature of industry, business, or establishment in which employed (or employer) Tailoring House

(c) Name of employer Rone & Cassell, Germany

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records (Address)

15 Filed MAR 30 1923, 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to March 28, 1923.

that I last saw h alive on March 28, 1923,

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate.
Chronic nephritis.
Hydrone Throsis.
Unknown
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No Laboratory.

What test confirmed diagnosis? B. W. Rhodes, M. D.

(Signed) , 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

London Park 3/30 1923

20 UNDERTAKER — ADDRESS

E J Fanning & Son 1938 E. Lafayette Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74301

CERTIFICATE OF DEATH.

159-002

D74301

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Eastern ave ST., 3 WARD)

2-FULL NAME Julian Frank Staniewicz

(a) RESIDENCE NO. 1530 Eastern ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Melvin Staniewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Helen Chojnska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Melvin Staniewicz
(Address) 1530 Eastern ave

15 Filed MAR 30 1923 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 29th, 1923, to Mar 29th, 1923, that I last saw him alive on Mar 29, 1923, and that death occurred, on the date stated above, at 10,25 P m.

The CAUSE OF DEATH* was as follows:

Natural Heart Lesion

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Open Foramen Ovale

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blue skin

(Signed) J Wade, M. D.

, 19 (Address) 116 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: March 30 1923

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank st

Spec.—1-10-21—M&T—1500 Blks.

Chism

HEALTH DEPARTMENT--CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D74302

REGISTERED NO. D74302

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1224 Bayard ST., 7 (WARD)

2-FULL NAME Laura Chism

(a) RESIDENCE No. 1224 Bayard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col'd	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Chism

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Thomas Chism

(Address) 1224 Bayard St

15 Filed MAR 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1923, to March 27, 1923, that I last saw him alive on March 27, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

1 Bronchial Pneumonia (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav Gotsman, M. D.

, 19 (Address) 856 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 3-30 1923

20 UNDERTAKER Dunn & Taylor — ADDRESS 916 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74303
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31 D74303
REGISTERED NO. C

CITY OF BALTIMORE: (No. 1018 N. Chapel ST.; 7 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Giles

(Residence in Baltimore: No. 1018 N. Chapel St St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	Married

6-DATE OF BIRTH, Aug. (Month) ? (Day), 1897. (Year)

7-AGE,	If LESS than 1 day,
25 yrs. 7 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: General Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE (State or Country): Chesterfield Co. Va

PARENTS.

10-NAME OF FATHER: Phil Barber

11-BIRTHPLACE OF FATHER (State or Country): Va

12-MAIDEN NAME OF MOTHER: Helen Crew

13-BIRTHPLACE OF MOTHER (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Columbus Giles (Husband)

(Address) 1018 N. Chapel St

15- Filed MAR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16 1923, to March 28 1923, that I saw h[er] alive on March 27 1923, and that death occurred, on the date stated above, at 8 30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemmorrhage
due to Pulmonary T.B.
(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) R J Young M. D.
3/28, 1923. (Address) 1029 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetary — DATE OF BURIAL, April 1, 1923

20-UNDERTAKER Jos. F. H. Rochester — ADDRESS 1413 Jefferson St

important. See instructions on back of certificate.

Spec.–1-10-21–M&T–1500 Bks.

D74304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 D74304

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Stevan Stanojev

(a) RESIDENCE NO. Ellicott City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Stanojev

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O H O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Milos Stanojev

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Sosa — ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mary Stanojev (Address) Ellicott City

15 MAY 30 1923 ROBERT E. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 29 - 1923

17

I HEREBY CERTIFY, That I attended deceased from 1-26, 1923, to 3-29, 1923, that I last saw him alive on 3-29, 1923, and that death occurred, on the date stated above, at 12 35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of larynx & oesophagus (duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Metastic carcinoma of lungs (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 3-1-23

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Milton L Lang, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mch 31 1923

20 UNDERTAKER R. Jones — ADDRESS 1111 Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74305

CERTIFICATE OF DEATH.

101-001

D74305

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St Josephs Hosp ST.: 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip J. Garrity

(a) RESIDENCE. NO. Mt St Joseph's College ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Unknown

14 Informant Bro. Philip C.F.X., (Address) Mt St Jos College

15 Filed MAR 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to March 28, 1923, that I last saw h[e] alive on March 28, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt St Jos College

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. A Tuell, M. D.

3/29, 1923 (Address) Irvington

*State the Disease Causing Death, (or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Mar 31 1923
20 UNDERTAKER	ADDRESS
Fred A. Krause & Son	733 Hanover St.

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Read statement on reverse side. ATTENTION is very important. See instructions on back of certificates.

Spec—12-23-2—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74306 D74306

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip Katz

(a) Residence No. ? St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 62 yrs. ? mos. ds. If LESS than 1 day, hrs. or min. ?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- MAR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 22, 19 23 to March 28, 19 23 that I last saw him alive on March 28 19 23 and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Ucko M. D.

3-29-. 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Woodlawn	March 31, 1923

20-UNDERTAKER.	ADDRESS
Martin W. E. Deffet	37 S. Amity St

In plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74307 D74307

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3706 Hickory Ave ST. 13 WARD)

2-FULL NAME Phoebe Melhorn.

(a) RESIDENCE. No. 3706 Hickory Ave ST. 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. 11 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Melhorn

6 DATE OF BIRTH (month, day, and year) 3/31/1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Interment (Address) Kirk Melhorn Brown's York Haven Pa

15 Filed MAR 30 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/23

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1922 to March 30, 1923 that I last saw h[illegible] alive on March 30 1923 and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Duodenal Ulcer.

(duration) 2 yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Valvular Cardiac

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Depi

(Signed) C. F. Culbert M. D.

3/24 1923 (Address) 3701 Eden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: March 31 1923

20 UNDERTAKER — ADDRESS

Chenoweth & Son Chestnut Ave

TION is very important. See instructions on back of certificates.

D74308 HEALTH DEPARTMENT—CITY OF BALTIMORE D74308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No.) Homewood Hospital ST. 1 6 (WARD) 202 Charles St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Edgar Shilling

(Residence in Baltimore: No. 3627 Cedar Ave. 33 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Oct. (Month) 15 (Day), 1889 (Year)

7-AGE, 33 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manager Roofing Dept.
(b) General nature of industry, business, or establishment in which employed (or employer): Pen Mar Co

9-BIRTHPLACE. (State or Country) Carroll Co. Md.

PARENTS.

10-NAME OF FATHER, Elias Shilling

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co Md.

12-MAIDEN NAME OF MOTHER Emma J Davis

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Effie C Shilling

(Address) 3627 Cedar Ave.

15- MAR 30 1923 ROBERT R. KRAUTER, 191 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

Shock & Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ... (Coroner) M. D.

March 29 1923 (Address) 2632 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem.	March 31. 1923.
UNDERTAKER, Horace H. Burgee	ADDRESS 363 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74309

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Gladden

(a) RESIDENCE NO. Lft 1607 Pennsylvania Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. mos. ds. How long in U. S., if of foreign birth? Lft yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 14 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Gladden

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Biddle

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Ruth Gladden

(Address) 101 Hanwood Place

15 Robert P. Harrison, Registrar

3 1 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to March 29, 1923, that I last saw him alive on March 29, 1923, and that death occurred, on the date stated above, at 2:20 P m.

The CAUSE OF DEATH* was as follows:

Measles.

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Billingsley M. D.

3/29/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 31 1923
20 UNDERTAKER Mrs Robert F Elliott	ADDRESS 1725 Oakland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74310

CERTIFICATE OF DEATH.

1401-001

D74310

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 Pitcher, St.; 14 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Lewis

(Residence in Baltimore: No. 627 Pitcher St. 13 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1883
(Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: waiter 070
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jesse Lewis

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosie Lewis (wife)

(Address) 627 Pitcher St.

15-

Filed ....., 191 9 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14 1923, to March 29 1923, that I saw h[illegible] alive on March 26 1923, and that death occurred, on the date stated above, at 10-30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Pleurisy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Dougherty M. D.

Mar. 30, 1923 (Address) 602 Penna. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Monkton Md

DATE OF BURIAL, Mar. 31st, 1923

20-UNDERTAKER Joseph A. Farrell

ADDRESS 2319 Division St

important. See instructions on back of certificate.

R 3 11923 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74311

CERTIFICATE OF DEATH.

D74311

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 N. Gilmore ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walter Jackson

(a) RESIDENCE. No. 312 N. Gilmore ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) 6-9-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): XXXXX

(c) Name of employer: XXXXX

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Columbus Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gloucester Co. Va.

12 MAIDEN NAME OF MOTHER Mary Baytop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gloucester Co. Va.

14 Informant: Mary Jackson

(Address) 312 N. Gilmore Street

15 Robert P. Harrison, Registrar

3 1 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1923, to Mar. 28, 1923, that I last saw him alive on Mar. 28, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William A. Harris, M. D.

19 (Address) 1200 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	3/31 1923

20 UNDERTAKER Samuel J. Hemsley ADDRESS 711

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74312

CERTIFICATE OF DEATH.

38 D74312

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital WARD)

2-FULL NAME Thomas J. Martin

(a) RESIDENCE NO. 111 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3½ yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Delia Jordan

6 DATE OF BIRTH (month, day, and year) Unknown 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe shoer

(b) General nature of industry, business, or establishment in which employed (or employer) 036

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Philip Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marianne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Philip Morton Jr

(Address) 536 Hilborn St

15 Filed 3 1 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to March 29, 1923, that I last saw him alive on March 29, 1923, and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Ruptured aneurysm of aorta

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Syphylis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? P.S.&S and autopsy

(Signed) John J. Krager, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 2 '23
20 UNDERTAKER Edward Kavanaugh & Son	ADDRESS
Per H J Cowan	901 Holbrook St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74313

CERTIFICATE OF DEATH.

1924 001 D74313

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 South Gilmor ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel W. Leonard

(Residence in Baltimore: No. 2 S. Gilmor St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Mar 29, 1923 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
76 yrs. ....mos. ....ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Geo. W. Leonard

11-BIRTHPLACE OF FATHER (State or Country), Hagerstown Md

12-MAIDEN NAME OF MOTHER, Martha Eliza Murr

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilbur W. Leonard

(Address) 169 E. Lamont St

15-

Filed ....., 1923 Robert P. Harrison, Jr. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 29, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 23 1923, to Mar 29 1923, that I saw h.. alive on Mar 29 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of brain

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) 2 yrs. ....mos. ....ds.

(Signed) Thos. H. Buckley M. D.

....., 191... (Address) 2300 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	Mar. 31 1923

20-UNDERTAKER	ADDRESS
Robert Brookman	Calhoun Holland

important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90

D74314

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2202 Mt Royal Terr. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Margaret S. Nelson

(a) Residence No. 2202 Mt Royal Terr St., Ward Bel Air Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 17-1562

7-AGE, 60 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Fredericksburg (State or Country), Va

PARENTS.

10-NAME OF FATHER, Wm B Nelson

11-BIRTHPLACE OF FATHER (city or town)... Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary E Worthington

13-BIRTHPLACE OF MOTHER (city or town)... Balto Co (State or Country), Md

14- (Informant)... Mrs Wm B Nelson

(Address)... 2202 Mt Royal Terr

15- Filed..... Robert P. Harrison, Registrar.

3 1192 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from April, 1921, to March, 1923, that I last saw her alive on March 27, 1923, and that death occurred, on the date stated above, at 12.10 Am.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Hypertension – Myocarditis

In my knowledge (Duration)... 2 yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?... no Date of.....

Was there an autopsy?... no

What test confirmed diagnosis?.....

(Signed)... W B Hopkins, M. D.

, 19 (Address) Belair, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Rock Spring	Mar 31, 1923
20-UNDERTAKER,	ADDRESS
John D Mitchell	2201 W Fayette

instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74315

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D74315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Broadway ST. 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin R. Hayden

(a) RESIDENCE NO. 1101 Broadway ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 1, 1922

7 AGE — Years: — Months: 9 Days: 29 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm R. Hayden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Cora V. Kinaca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Wm R. Hayden 1101 N. Broadway

Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1923. to March 29, 1923. that I last saw him alive on March 29, 1923., and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Bronicho Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Walter W. White Jr. M. D.

3/30 1923 (Address) 2800 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL March 31 1923

20 UNDERTAKER Herbert Fickler — ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

R 3

Spec.—1-10-21—M&T—1500 Bks.

D74316

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D74316

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 E. Chase ST., 8 WARD)

2-FULL NAME Mellie E. Adkins

(a) RESIDENCE NO. 1624 E. Chase ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 20, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Lloyd Adkins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Katie Lowe

13 BIRTHPLACE OF MOTHER (city or town) Del.
(State or country)

14 Informant George Lowe
(Address) 1624 E. Chase

15 Robert P. Harrison, 19..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 20, 1923, to Mar 30, 1923, that I last saw he alive on Mar 30, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ..... over

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Lucy L. Whitehurst, M. D.

Mar 30 1923 (Address) 1038 W Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Mch 31 1923

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3 1 1923

Spec—12-23-21—E.B.R.S.—400 Blks.

D74317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2224 Eagle St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agustus E. Knight

(a) Residence No. 2224 Eagle St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Theresia Knight

6-DATE OF BIRTH (month, day and year) April 2, 1872

7-AGE. 51 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Machanicall

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Augustus Knight

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Katherine Carey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Theresia Knight

(Address) 2224 Eagle St

15- MAR 31 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 29-23

17- I HEREBY CERTIFY, That I attended deceased from March 1 1923, to March 29 1923

that I last saw him alive on March 29 1923

and that death occurred, on the date stated above, at 7.55 A. m.

The CAUSE OF DEATH* was as follows:

Carcinomata of Stomach

Pyloric

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Gutsch M. D

3/30 1923 (Address) 2151 Wilkens Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	April 2 1923
20-UNDERTAKER, George J. Smith	ADDRESS 1532 Hollins

Spec.—8-24-14—M. & T.—2000 Blks.

D74318

HEALTH DEPARTMENT—CITY OF BALTIMORE

6 122-002 D74318

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3907 Bateman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hogan

(Residence in Baltimore: No. 3907 Bateman St.: 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. [illegible] (Month) 14 (Day) 1849 (Year)

7-AGE.	If LESS than 1 day,
74 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Patric Moran

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Bridget Moran

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Hogan

(Address) 3907 Bateman

15- Robert F. Harrison,
Filed ..... 191.....
1923 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 16 1923, to Mar 30 1923, that I saw her alive on Mar 30 1923, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
Tuberculosis of Lungs
Cirrhosis of Liver
(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mary F. Dreyer M. D.
Mar 31, 1923 (Address) 1 N. Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral	April 3, 1923
20-UNDERTAKER Robt J. Turner	ADDRESS 1441 Broadway

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Nbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74319 99-00 D74319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Just inside City Line South of Taylor ave

CITY OF BALTIMORE: (No. Harford Road ST., 27 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Brennen

(a) RESIDENCE NO. Harford Road S of Taylor ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F Brennen

6 DATE OF BIRTH (month, day, and year) Apr 4th 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Barrickman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Anna E Brennen
(Address) Harford Rd S of Taylor ave

15 Filed 3 14 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 23, 1923, to Mch 29, 1923, that I last saw her alive on Mch 29, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Infirmities of Age

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

3/30 1923 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL April 3rd 1923

20 UNDERTAKER George B Willing & Sons — ADDRESS 1126 E Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact name of disease, not mode of dying, must be given. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

(May Reading)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74320

D74320

CERTIFICATE OF DEATH.

X 100 89

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp ST., 7 WARD)

2-FULL NAME Reading May

(a) RESIDENCE No. Rockville, Md. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reading Joseph

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56	no data			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm Sassaway.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Johns Hopkins Hospital nurse.
(Address)

15 Filed 3 1 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to March 31, 1923,

that I last saw her alive on March 30, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Infection of unknown origin

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? Rockville Md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred Allen, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Md. — DATE OF BURIAL April 1923

20 UNDERTAKER W. J. Tickner & Son — ADDRESS Rockville Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74321

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 25 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Caskan

(a) RESIDENCE NO. 329 Maryland Ave., Westport, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8th, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Martin Caskan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Bertha Balliet

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Martin Castagnera

(Address) 359 Maryland Ave

15 Filed 19 Robert P. Harrison, Registrar

3 11923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30th 1923

17

I HEREBY CERTIFY, That I attended deceased from February 19th, 1923, to March 30th, 1923,

that I last saw him alive on March 30th, 1923,

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis + myocarditis

(duration) About yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia + emphysema, left (duration) About yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Feb. 20th

Was there an autopsy? no.

What test confirmed diagnosis? Clinical course + exam.

(Signed) Jno. F. Finney Jr. M. D.

March 25, 1923 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 4/2 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

1 Flute Broadway. Chase 99.00

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74322

CERTIFICATE OF DEATH.

D74322

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2243 East North St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dorothea A. Tomsollen

(a) Residence No. 2243 East North St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Harry W. Tomsollen

6-DATE OF BIRTH (month, day and year) 1-20-1864

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Philip Schmidt

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Dorothea Tomsollen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Harry W. Tomsollen

(Address) 2243 East North

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 29-23

17- I HEREBY CERTIFY, That I attended deceased from Jan 17 1923 to March 29 1923

that I last saw h. alive on March 29 1923

and that death occurred, on the date stated above, at 245 P m.

The CAUSE OF DEATH* was as follows:

Raynauds Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter H White Jr M. D.

3/30, 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Emanuel Cemetery

DATE OF BURIAL, 4/2 1923

20-UNDERTAKER. Wm Cook

ADDRESS 502 S North Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

Magness
1206 E. Preston

D74323 HEALTH DEPARTMENT—CITY OF BALTIMORE 7400 D74323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 315 N. Carey St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jane Ruth

(a) Residence No. 315 N. Carey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 15-1850

7-AGE, 73 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Harford Co Md

PARENTS.

10-NAME OF FATHER: John W. Ruth

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Harford Co

12-MAIDEN NAME OF MOTHER: Elizabeth Wright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Harford Co

14- (Informant): Jennie Harding

(Address): 1206-E Preston

15- Filed 4 1923, 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 30-23

17- I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to May 30, 1923

that I last saw h[illegible] alive on May 30, 1923

and that death occurred, on the date stated above, at 1201 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) S. Ly Magness, M. D.

3 30, 1923 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Run Harford Co | DATE OF BURIAL, 4/2, 1923

20-UNDERTAKER: Wm Cook | ADDRESS 502 E North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D74324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. Calvert St., 10 Ward)

Registered No. 75-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Grace Cook

(a) Residence No. 1018 E. Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, —, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Alex Cook.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Ruth Carroll.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Charles H. Cook

(Address) 1018 E. Monument

15-

Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-30-23

17- I HEREBY CERTIFY, That I attended deceased from March 25, 1923 to March 30, 1923

that I last saw her alive on March 30, 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia.

(Duration) yrs. mos. 16 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) D. J. Perugino M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount	4/3, 1923
20-UNDERTAKER. Wm Cook	ADDRESS 502 E North

3

All spaces to be filled in. See instructions on back of certificates.

Dr Fenton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74325

CERTIFICATE OF DEATH.

101-001

D74325

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 846 Dr. Peter St. 21 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Raum

(Residence in Baltimore: No. 846 St Peter St.: 1yr., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, March (Month) 5 (Day), 922 (Year)

7-AGE, ...1.... yrs. ....25.... mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: John G. Raum

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Lucy Smith

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John G. Raum

(Address) 846 St Peters St

15-

Filed ....., 191.....

Robert P. Harrison,

Registrar.

3 1 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, mar (Month) 3 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H Fenton M. D. (Coroner.)

Mar 7 1923 (Address) 700 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, March 31, 1923

20-UNDERTAKER Wm Cook

ADDRESS 512 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74326

CERTIFICATE OF DEATH.

159-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 S Bradford ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boleslaus Monszewski

(a) RESIDENCE No. 625 S Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md Md

PARENTS

10 NAME OF FATHER Alexander Monszewski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Weronika Bartkowiak

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Alexander Monszewski (Address) 625 S Bradford St

15 Filed 19 Robert P. Harrison, Burial Permit Clerk Registrar

3 11923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 19

17

I HEREBY CERTIFY, That I attended deceased from March 29, 19 23, to March 31, 19 23,

that I last saw h alive on March 31, 19 23,

and that death occurred, on the date stated above, at 130 Am.

The CAUSE OF DEATH* was as follows:

acute bronchitis

pneu

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Alanus A Dewland M.D.

19 (Address) 3325 Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A.A. Co — DATE OF BURIAL: March 31 23

20 UNDERTAKER: JOhn M.Weber 1803 — ADDRESS: Bank s

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the CONDITION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital Malformation.

Spec.—1-10-21—M&T—1500 Blks.

D74327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74327

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 18 WARD)

2-FULL NAME Alice Corbett

(a) RESIDENCE NO. Saratoga et. ST., ... WARD .....
(Usual place of abode) 822 W. Lombard st. (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. T. Murray

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Cusby Disney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) M.T.H.

UNIVERSITY OF MARYLAND

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24th, 1923, to March 27, 1923, that I last saw her alive on March 27, 1923, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? X-ray

(Signed) Francis A. Sadoplaces M. D.

3-27-1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

3 1923 Dr. and buried in Mt Olivet Cem April 93 MAR 31 1923

Wm Cook

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74328

84

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1017 E. Biddle ST., 10 WARD)

2-FULL NAME Catherine Gehring

(a) RESIDENCE NO. 1017 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Gehring

6 DATE OF BIRTH (month, day, and year) Nov 18-1830

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	92	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Pa
(State or country)

PARENTS

10 NAME OF FATHER Philip Debeauch

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Stricker

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hugh Gehring
(Address) 1017 E. Biddle St.

15 Filed MAR 9 1923 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 28th 1923, to March 28th 1923.
11.30 a.m. 7 p.m.

that I last saw h[illegible] alive on March 28th 1923, at 4.30 p.m.

and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

10 hours.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arthritis.
(duration) 25 yrs. mos. da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Wilmer Brinton, M. D.

19 (Address) S.W. Cor. Lexington & Eutaw Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Govans Cemetery	1923
20 UNDERTAKER	ADDRESS
M. C. Nudelfeld	914 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74329

CERTIFICATE OF DEATH.

146 D74329

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. St Josephs Hospital ST., 10 WARD)

2-FULL NAME Elizabeth Carroll

(a) RESIDENCE NO. 60 r E Eager St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Carroll

6 DATE OF BIRTH (month, day, and year) May 17-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or.....min.
	21	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of Industry, business, or establishment in which employed (or employer) Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Baynes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Henry J. Carroll

(Address) 60 r E Eager St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/16, 1923, to 3/30, 1923.

that I last saw h Sh alive on 3/30, 1923,

and that death occurred, on the date stated above, at ..... P m.

The CAUSE OF DEATH* was as follows:

Puerperal Peritonitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) following Labor on 3/12/23

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 60 r E Eager St

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Dr Bernard Wise, M. D.

3/30, 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral — DATE OF BURIAL April 3 1923

20 UNDERTAKER H. C. Widefeld — ADDRESS 914 E Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74330

D74330

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 Linden Ave ST., 11 WARD)

2-FULL NAME Harvey Middleton

(a) RESIDENCE NO. 1227 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Male	White American	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Cornelia Scribner Middleton

6 DATE OF BIRTH (month, day, and year) June 27 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mec Engineer retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penn

PARENTS

10 NAME OF FATHER Nathan Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Penn

12 MAIDEN NAME OF MOTHER Hannah Alberton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Penn

14 Informant Mrs Harvey Middleton

(Address) 1227 Linden Ave Balto

15 Filed ..., 19... Robert F. Lar... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1923

17

I HEREBY CERTIFY, That I attended deceased from ..., 1915, to 3/30 1923,

that I last saw him alive on 3/30, 1923,

and that death occurred, on the date stated above, at one P m.

The CAUSE OF DEATH* was as follows:

Femoral arteriosclerosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

3/30 1923 (Address) 1028 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 4/2/1923

20 UNDERTAKER H. W. Jenkins Son Co

ADDRESS Orchard & McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74331

CERTIFICATE OF DEATH.

D74331

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3432 E Lombard ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha M. Schock

(Residence in Baltimore: No. 3432 E. Lombard St.; ..... yrs., 9 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	S.

6-DATE OF BIRTH, ... June (Month) 19 (Day), 1922 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 9 mos. 11 ds.	.... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER. Geo Schock

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Elizabeth Webber

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Schock

(Address) 3432 E. Lombard

15-

Filed ..... Robert ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3/31/23 (Month) (Day) (Year), 191...

17- I HEREBY CERTIFY, That I attended deceased from 3/29/23 191..., to 3/31/23 191..., that I saw h... alive on ..... 191..., and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

..... Measles

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) ..... none .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Frederick Heinemann M. D.

3/31/23, 191... (Address) ..... 1914 E Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	3/31, 1923

20-UNDERTAKER	ADDRESS
Emily Herwig	2016 Orleans

Important. See instructions on back of certificate.

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74332

D74332

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Waters

(a) RESIDENCE NO. 1619 Sarah Ann St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
38	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Carrell Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Robert P. Harrison, Registrar

MAR 31 1923 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 19 23

17 I HEREBY CERTIFY, That I attended deceased from February 2, 19 23, to March 26, 19 23,

that I last saw him alive on March 26, 19 23,

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Decubitus

Anemia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. M. Shipley per C.M. M. D.

3-27-19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Robinson Cem Mar 31 19 23

20 UNDERTAKER — ADDRESS

Brown & Sons & Sanders & Schroder

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74333

CERTIFICATE OF DEATH. X 100-001 D74333

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hospital School St.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Holland

(Residence in Baltimore: No. 2070 Gay St.; ..... yrs., 3 mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. October (Month) 15 (Day), 1920 (Year)

7-AGE. 2 yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Aubrey Holland

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ida K. Meredith

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R.E. Lenhard

(Address) Childrens Hosp. Sch.

15-

Filed ....., 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 11 1923, to March 30 1923, that I saw her alive on March 30, 1923, and that death occurred, on the date stated above, at 3 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) 2 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Amyotonia Congenita

(Duration) 2 yrs. 5 mos. 15 ds.

(Signed) R. E. Lenhard M. D.

March 30 1923 (Address) Childrens Hosp Sch

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 19 ds. In the State 2 yrs. 5 mos. 15 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence Rumbley, Somerset, Co. Md

19-PLACE OF BURIAL OR REMOVAL: Westover Somerset Co Md — DATE OF BURIAL, April 1, 1923

20-UNDERTAKER John Dillon — ADDRESS 2008 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74334

CERTIFICATE OF DEATH.

90 D74334

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 E Pratt ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Command

(a) RESIDENCE. NO. 1717 E Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 19 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John H Command

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael Command
(Address) 1717 E Pratt

15 Filed 19 Robert P. Harrison, Registrar

R 3 11923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March-25, 1923, to March 30-, 1923

that I last saw her alive on March 25-, 1923

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Heart block - (Cardiac Paralysis
— Auto —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fatty deg - of Heart - (Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? md

(Signed) Hope Bonner, M. D.

, 19 (Address) 125 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	April 19
20 UNDERTAKER	ADDRESS
Wendell Ryfell & Son	318 W

CAUSE OF DEATH must be plainly written, and certificate filled out in full. See reverse side of certificates.
TION is very important. See instructions on back of

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74335

CERTIFICATE OF DEATH.

11-00 D74335

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 802 N. Gilmor ST., 16 WARD)

2-FULL NAME Susan Pepoon

(a) RESIDENCE NO. 802 N. Gilmor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lycurgus Pepoon.

6 DATE OF BIRTH (month, day, and year) May 5-1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Nathan Morse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Cassandra Bliss.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant Willis Pepoon (Address) 802 N. Gilmor St.

Filed 3 1 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 20th 16, 1923, to March 29, 1923, that I last saw her alive on March 29, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Grip (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 802 N. Gilmor St.

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Painesville Lake Co. Ohio.

DATE OF BURIAL Mar 31st 1923

20 UNDERTAKER Bertram Gore

ADDRESS 1723 W. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74336 HEALTH DEPARTMENT—CITY OF BALTIMORE D74336

74-00

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2109 N. Calvert St St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonora Parks Lansdowne

(a) Residence No. 2109 N Calvert St St., 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 0 mos. 21 ds. How long in U. S., if of foreign birth? 76 yrs. 0 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. E. S. Lansdowne

6-DATE OF BIRTH (month, day and year) March 9-1847

7-AGE. 76 yrs. 0 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER Lloyd B Parks

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Md

12-MAIDEN NAME OF MOTHER, Leonora B Starr

13-BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or Country) Pa

14-(Informant) Mr Geo. E. S. Lansdowne (Husband)

(Address) 2109 N. Calvert St

15-Filed ....., 192.... Registrar.

3 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/30/23

17-I HEREBY CERTIFY, That I attended deceased from 3/26 19 23 to 3/30 19 23

that I last saw h.. alive on 3/29 19 23

and that death occurred, on the date stated above, at 8:54 a.m.

The CAUSE OF DEATH was as follows:

Apoplexy

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D

3/31 19 23 (Address) Roland Park

Fully state the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Greenmount Cemetery	March 31, 1923

20-UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)	108 W. NORTH AVE.

All parts must be filled in. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

D74337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74337

CERTIFICATE OF DEATH.

X 123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Freakle

(a) RESIDENCE NO. Whitestone Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Whitestone Va.
(State or country)

PARENTS

10 NAME OF FATHER G. W. Sanders

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Whitestone Va.

12 MAIDEN NAME OF MOTHER Lucy A. Sprigg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Hosp. records
(Address)

15 Filed 1923, Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1923, to Mar 30, 1923,
that I last saw h.r alive on Mar 30, 1923,
and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis
Choledocholithiasis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/23
Removal of Stone from common duct

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Anthony V. Buchness, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White Stone Va — DATE OF BURIAL April 1 1923

20 UNDERTAKER Harry W. Witzke — ADDRESS 1531 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of facts is very important. See instructions on back of certificates.

3

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74338

CERTIFICATE OF DEATH.

99-002 D74338

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 E. North Ave ST., 9 WARD)

2-FULL NAME Mary Hilbert

(a) RESIDENCE NO. 800 E North Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 0 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of George Hilbert

6 DATE OF BIRTH (month, day, and year) Nov. 27th 1849

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Gonnades

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Nedderneyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Walter Hilbert
(Address) 800 E. North Ave

15 3 1 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1921 to March 29th 1923, that I last saw h.. alive on March 28th 1923, and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 2 yrs. mos 29 ds.

CONTRIBUTORY (Secondary) Acute cardiodilatation

(duration) ..... yrs. mos. 5 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) P. E. Filby, M. D.

, 19 (Address) 800 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL 3/31/23

20 UNDERTAKER: Geo. C. Finley — ADDRESS Fulton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on ... s on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74339

CERTIFICATE OF DEATH.

129 D74339

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3215 Belmont Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna V. Chrystal

(a) RESIDENCE NO. 3215 Belmont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Chrystal

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	about 80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co., (State or country) Md.

PARENTS

10 NAME OF FATHER William Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co., Md

14 Informant Mrs Augusta C. Lee

(Address) 3215 Belmont Ave

15 FILED APR 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 28, 1923, to Mar 30, 1923,

that I last saw h.. alive on Mar 30, 1923,

and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

(a) Interstitial Nephritis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical & Urinary Analysis

(Signed) C. L. Mayfield M. D.

3/31. 1923 (Address) Calvert Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery, Govans — DATE OF BURIAL April 2 1923

20 UNDERTAKER Henry W. Meads & Son — ADDRESS 805 N. Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D74340

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Ditmans Court ST.: 16 WARD)

2-FULL NAME Jerome Gross

(a) RESIDENCE. No. 1706 Ditmans Ct. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 19. 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ernestine Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Ernestine Gross
(Address) 1706 Ditmans Ct.

15 Filed APR 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29- 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27th, 1923, to March 30th, 1923, that I last saw him alive on March 29th, 1923, and that death occurred, on the date stated above, at 4:35 a.m.

The CAUSE OF DEATH* was as follows:

Acct. Appendicitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter Dorsey, M. D.

, 19 (Address) 16 Rd mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-1- 1923
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Eade

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74341

CERTIFICATE OF DEATH.

74-001 D74341

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 658 Sarah Ann Street ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Howard

(a) RESIDENCE. No. 658 Sarah Ann Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Robert Howard

6 DATE OF BIRTH (month, day, and year) 3-4- 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): XXXXX

(c) Name of employer: XXXXX

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Gassaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howerd Co. Maryland

12 MAIDEN NAME OF MOTHER Mary L. Fisher

13 BIRTHPLACE OF MOTHER (city or town) Poughkeepsie (State or country) New York

14 Informant Desdemonia Porter nee Howard
(Address) 658 Sarah Ann St.

15 Filed APR 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 28. 1923 to March. 28th. 1923
that I last saw her alive on 28 March 1923.
and that death occurred, on the date stated above, at 7.30 P m.
The CAUSE OF DEATH* was as follows:

Nephritis
Arteric-Sclerosis
(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy
(duration) 2 Hours yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William A. Harris, M. D.
, 19 (Address) 1200 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dist Auburn Bur	April 1923
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

CAUSE OF DEATH to be plainly written, and every item must be answered. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74342

CERTIFICATE OF DEATH.

D74342

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 338 W Lanvale St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Wm Fridley

(a) Residence No. 1338 W Lanvale St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Agnes

6-DATE OF BIRTH (month, day and year) May 7 1860

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Samuel Fridley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Hamman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Fridley

(Address) 1335 W Lanvale

15- APR 1 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 30 1923

17- I HEREBY CERTIFY, That I attended deceased from March 22 1923 to March 30 1923 that I last saw him alive on March 30 1923 and that death occurred, on the date stated above, at 1.7 AM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'Neill M. D.

3/31 1923 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount — DATE OF BURIAL, March 22 1923

20-UNDERTAKER, Wm Cook — ADDRESS 512 E. Lan.

Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74343

CERTIFICATE OF DEATH.

129

D74343

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2167 Chelsea Ter ST., 15 WARD)

2-FULL NAME Talethia Williams Mullikin

(a) RESIDENCE NO. 2167 Chelsea Ter ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Beale D. Mullikin

6 DATE OF BIRTH (month, day, and year): Mar 28 1838

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
85	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Saml. H. Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Dunle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robt. L. Harper.
(Address) 2167 Chelsea Terrace

15 APR 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to March 30, 1923, that I last saw her alive on March 30, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis Parenchymatous Nephritis - High blood pressure.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. S. Nibbett, M. D.

3/30/23 19 (Address) 2220 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leland Md — DATE OF BURIAL: Apr 2 1923

20 UNDERTAKER: Wm. Fleischer & Sons — ADDRESS: North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH statement of SECTION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74344

CERTIFICATE OF DEATH.

90

D74344

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2211 N. Charles St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Amelia Thode

(a) Residence No. 2211 N. Charles St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 8 1852

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Libertus Van Bokelen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N.Y.

12-MAIDEN NAME OF MOTHER. Amelia R.D. Arey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs Amelia V. Allison

(Address) 2211 N. Charles St.

15- Filed APR 1 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 30 1923

17- I HEREBY CERTIFY, That I attended deceased from March 21, 1923, to March 30, 1923, that I last saw h.r alive on March 30, 1923, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Mitral Heart Disease and High Arterial Tension

(Duration) Many yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Auscultation of heart + Blood Pressure machine.

(Signed) Jas. M. Cranghill, M. D.

Apl 4, 1923 (Address) 1800 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem. DATE OF BURIAL, Apl 2, 1923

20-UNDERTAKER. John D. Miller ADDRESS. 1201 W. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

D74345

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74345

CERTIFICATE OF DEATH.

41

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 W. North Ave. WARD 15)

2-FULL NAME Frances Cotton

(a) RESIDENCE NO. 2210 W. North Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Godfrey Cotton

6 DATE OF BIRTH (month, day, and year): Jany. 24, 1869

7 AGE — Years: 54 — Months: 2 — Days: 6 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bridgeport Conn.

PARENTS

10 NAME OF FATHER: Simon C. Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Ferngood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Godfrey Cotton 2210 W. North Ave

15 Filed APR 1-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/30/1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to March 30, 1923, that I last saw h[er] alive on March 30, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Streptococcus septicemia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Edema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (see reverse side)

(Signed) J Frederick Leitz, M. D.

, 19 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem — DATE OF BURIAL: 4/2/1923

20 UNDERTAKER: David Londheim — ADDRESS: 17-20 N. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of certificates.

TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74346

CERTIFICATE OF DEATH. 1 74-001 D74346

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3450 Reisterstown Rd. WARD)

2-FULL NAME Pauline E. Kahn

(a) RESIDENCE NO. 3450 Reisterstown Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis A. Kahn

6 DATE OF BIRTH (month, day, and year) Mch. 17 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Isaac Edheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER — Weisberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ferd. Kahn (Address) 3450 Reisterstown Road

15 Filed APR 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to March 30, 1923, that I last saw her alive on March 30, 1923, and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy (cerebral hemorrhage)

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Frederick Lentz M. D.

, 19 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 4/2/1923

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATION OF CONDITION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74347

CERTIFICATE OF DEATH.

117 D74347

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Md. General Hospital ST., 9 WARD)

2-FULL NAME Mrs Viola Garrett.

(a) RESIDENCE NO. 1921 Cecil Ave. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marvin Garrett

6 DATE OF BIRTH (month, day, and year) Nov. 28th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	26	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dallas Texas
(State or country)

PARENTS

10 NAME OF FATHER Max. Galloway

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Alabama

12 MAIDEN NAME OF MOTHER Cecil Hopkins

13 BIRTHPLACE OF MOTHER (city or town) Georgia
(State or country)

14 Informant Mrs. Garrett
(Address) 1921 Cecil Ave.

15 APR 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/1923

17 I HEREBY CERTIFY, That I attended deceased from 3/26/1923 to 3/30/1923.

that I last saw h.. alive on 3/30/1923

and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Appendicitis or pus tubes.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of 3/27/23

Was there an autopsy? No

What test confirmed diagnosis? Clynical Symptoms

(Signed) Jno A Simpkins M. D.

3/31/1923 (Address) Md Gen Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Austin Texas.	Apr. 1st 1923
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Bolton St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74348

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Fallsway ST., 16 WARD)

2-FULL NAME James A Griffin

(a) RESIDENCE NO. 600 N Carrollton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 3 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy P. Griffin

6 DATE OF BIRTH (month, day, and year) Dec 21 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James A. Griffin

11 BIRTHPLACE OF FATHER (city or town) Worthington
(State or country) D.C.

12 MAIDEN NAME OF MOTHER Hannah Kennedy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington D.C.

14 Informant Harry J. Griffin
(Address) 722 N Carrollton ave

15 Filed APR 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1st in 23, to March 30 23,
that I last saw h... alive on March 30, 23,
and that death occurred, on the date stated above, at 2:19 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
Pulmonary abscess

(duration) - yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Myocardial ulcer
(duration) 2 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/24/23

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John A Oconnor M. D.
, 19 (Address) South Balto Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 2 1923
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 Worth ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of each of certificates.
TION is very important. See instructions on back of

Spec.—1-10-21 M&T 1500 Blks.

D74349

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

100-001 D74349

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Vincents Infirmary

CITY OF BALTIMORE: (No. 1401 Division ST., 14 WARD)

2-FULL NAME Eugene Sommers

(a) RESIDENCE NO. 1401 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT IS ESSENTIAL. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md

PARENTS

10 NAME OF FATHER Henry Sommers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Sommers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Henry L. Sommers 13 Joseph St Canton

15 Filed APR 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923 to March 31, 1923, that I last saw him alive on March 31, 1923, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

over

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas-R. Goldborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: April 2 1923

20 UNDERTAKER: Jos Joerdens. Son — ADDRESS: 2173 Pa. Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74350

CERTIFICATE OF DEATH.

11-001

D74350

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 Gale Ave ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. M. Rosa Siehler

(a) RESIDENCE NO. 319 Gale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19 1884

7 AGE: Years 38 | Months 5 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Reisinger Siehler

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jacob Siehler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Susie Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Susie Siehler

(Address): 319 Gale Ave

15 Filed APR 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1st, 1923, to March 30, 1923.

that I last saw her alive on March 30, 1923.

And that death occurred, on the date stated above, at 5-0 m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Toxic Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) Henry Stahr, M. D.

3/31 1923 (Address) 23 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Apr 2 1923

20 UNDERTAKER: Jos Jacobs & Son

ADDRESS: 217 S. Pine

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of conditions on back of certificates.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D74351

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 244 S. Exeter st. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Pica

(a) RESIDENCE NO. 244 S. Exeter St, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: m

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15/1920

7 AGE — Years: 3 — Months: 5 — Days: 15 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Tony Pica

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Marie Grasso

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Univerity Hosp. Reeds

15 Filed APR 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/17, 1923, to 3/30, 1923,

that I last saw him alive on 3/30, 1923,

and that death occurred, on the date stated above, at 12:40 P. m.

The CAUSE OF DEATH* was as follows:

Metastatic Sarcoma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) not

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/17/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Sallister, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: April 2 1923

20 UNDERTAKER: George L. Ruth — ADDRESS: 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74352

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH Woman's Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No Lafayette ave E John ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Theresa W Heatley

(a) RESIDENCE NO. 1934 Mt Royal Terrace ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 6 mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced (or) WIFE of William F W Heatley

6 DATE OF BIRTH (month, day, and year) Sept 24 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward J Hilholland

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Saunders

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Wm F W heatley

(Address) 1934 Mt Royal Terrace

15 Filed APR 1 - 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 30 1923

17

I HEREBY CERTIFY, That I attended deceased from 2 - 15 , 1923 , to 3 - 30 , 1923 ,

that I last saw he r alive on 3 - 30 , 1923 ,

and that death occurred, on the date stated above, at 7:35 P m.

The CAUSE OF DEATH* was as follows:

Toxic myocarditis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Ruptured appendix with appendicular abscess.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2 - 16 - 23

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. H. Tyler M. D.

. 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additioonal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	April 2 1923
20 UNDERTAKER	ADDRESS
George F. Rust	1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT RESIDENCE OF DECEASED TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74353

CERTIFICATE OF DEATH.

10 D74353

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bishop

(a) RESIDENCE No. St. Vincents asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Not known

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant St Vincent Inf Asylum

(Address) Govd Avenue & Edmondson

15 Filed APR 1 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Remarks

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1923, to March 31, 1923, that I last saw h[illegible]ive on March 31, 1923, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal & laryngeal

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at St. Vincents

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B. McGowan, M. D.

4/1/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral | DATE OF BURIAL 4/1 1923

20 UNDERTAKER Martin Fuhrer | ADDRESS 527 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D74354

CERTIFICATE OF DEATH.

D74354

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2903 Norfolk Ave. 15 WARD)

2-FULL NAME Duncan MacCalman Macnab

(a) RESIDENCE. NO. 2903 Norfolk Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John B. Macnab

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Helen Macintyre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland.

14 Informant John B Macnab (Address) 2903 Norfolk Ave

15 Filed APR 1—1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24th, 1923, to March 31st, 1923, that I last saw him alive on March 31st, 1923, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual Clinical Diag

(Signed) D. W. Keown, M. D.

4/1/1923 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	4/1/23 19

20 UNDERTAKER Martin Kirby & Son ADDRESS 837 N. North

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Each statement of cause TION is very important. See instructions on back of certificates.

Albert J Long.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. × 90 D74355

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Long, Albert J.

(a) RESIDENCE NO. Summit Ave — ST., WARD Hagerstown - Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. A. J. Long.

6 DATE OF BIRTH (month, day, and year) May 13 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David Long.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Penn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed APR 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to March 31, 1923, that I last saw h alive on March 31, 1923, and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis — cardiac decompensation with pleural effusion and ascites.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hagerstown —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Fred H Allen, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	4-4 1923

UNDERTAKER Wm. F. Tolbert & Son Baltimore Md

Spec—12-23-21—E.B.R.S.—400 Blks.

74356 HEALTH DEPARTMENT—CITY OF BALTIMORE

D74356

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101-001 D74356

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Chas. L. Wright

(a) Residence No... 2223 Madison Ave. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed or divorced HUSBAND ~~or WIFE~~ of Ruby Wright

6-DATE OF BIRTH (month, day and year) Feb 4 1891

7-AGE. 32 years 3 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd Jobs

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Chas. L. Wright

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Talbot Co.

12-MAIDEN NAME OF MOTHER. Mary Martha Sinclair

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Talbot Co.

14- (Informant)..... Hospital Records

(Address).....

APR 2 - 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

In place of filling, see instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/31/23

17- I HEREBY CERTIFY, That I attended deceased from 3/31/1923 to death 2 hrs after 19..

that I last saw him alive on 3/31/1923.

and that death occurred, on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration)..... yrs. ..... mos. 7 ds. ?

CONTRIBUTORY .....
(Secondary)

(Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) H. Lowell Cowell, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Orleans La.	4/2/23, 19..
20-UNDERTAKER.	ADDRESS
H. E. Hughes	4th & Broadway

Spec.—4-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74357

100-001

D74357

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2338 W. Fayette ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Catherine Cerniglia

(a) RESIDENCE NO. 2338 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April-13-1911

7 AGE 11 Years 10 Months 11 Days 17

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Cerniglia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Clara Troidl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John Cerniglia (Address) 2338 W. Fayette St

15 APR 2-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30-23.

17 I HEREBY CERTIFY, That I attended deceased from March 28 1923 to March 30 1923 that I last saw her alive on March 30 1923 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E. P. Passano, M. D.

4.1.23 (Address) Dan Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cath. Cem.

DATE OF BURIAL 4/4/23

20 UNDERTAKER George Ruth

ADDRESS 1135 Hanford

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74358

CERTIFICATE OF DEATH.

101-001

D74358

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2931 Harlem Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Santo Zito

(a) RESIDENCE. No: 2931 Harlem Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria Zito

6 DATE OF BIRTH (month, day, and year): August 12 1864

7 AGE: Years 58 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fruit

(b) General nature of Industry, business, or establishment in which employed (or employer): Vendor 045

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: Santo Zito

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Maria Zito

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Maria Zito
(Address): 2931 Harlem Ave.

15 Filed APR 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 31 1923

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1923, to March 31, 1923, that I last saw him alive on March 31, 1923, and that death occurred, on the date stated above, at 630a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis and Probably Cerebral Tumor

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and X Ray

(Signed) Wm. R. Johnson, M. D.

3/31, 1923 (Address) 3928 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery DATE OF BURIAL: Apl 3 1923

20 UNDERTAKER: Geo. J. R[illegible] ADDRESS: 1233 Harford Ave.

CAUSE OF DEATH: Please print plainly. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

16 1916 — D74359 — 90 — D74359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) 7 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Kietzway.

(a) RESIDENCE NO. 815 Milton Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 6yrs. 11mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (")

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1884.

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ..... min.
38.	5	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Truckman.

(b) General nature of Industry, business, or establishment in which employed (or employer): (") 1923

(c) Name of employer: (")

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Frank Kietzway

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Madeline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: JOHNS HOPKINS HOSPITAL. Records. (Address)

15 Date Received: APR 2 - 1923

ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1923, to March 30, 1923, that I last saw him alive on March 30, 1923, and that death occurred, on the date stated above, at 10.00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis — Myocardial failure. — 1 yr.

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Streptococcus Septicaemia

(duration) — yrs. — mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. W. Cunningham M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakleaves Cemetery

DATE OF BURIAL: 4/3 1923

20 UNDERTAKER: George & Ruth

ADDRESS: 725 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificates.

D74360

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74360

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE (No. 1413 Bruce St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Tombs

(Residence in Baltimore: No. 1413 Bruce St. St.; yrs., 10 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, May 1, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William Tombs

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Stella Tolliver

13-BIRTHPLACE OF MOTHER (State or Country), Wash. D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estella Tombs

(Address) 1413 Bruce St.

15-

Filed APR 2 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said....(Inquest, autopsy or inquiry.) and that said deceased came to....death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Bronchopneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)

March 31, 1923 (Address) 320 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	April 4, 1923
20-UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74361

CERTIFICATE OF DEATH.

100-00 D74361

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 Division ST. 17 WARD)

2-FULL NAME Emil Gurs

(a) RESIDENCE NO. 1210 Division ST., 17 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 12/8/1919

7 AGE: Years 3; Months 3; Days 22; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Fredrick Turks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Addie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Addie B. Turks 1210 Division Street

15 APR 2-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/31/1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1923 to Mar 31, 1923, that I last saw h. alive on Mar. 30, 1923, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Thompsina, M. D.

. 19 (Address) 1019 Mill Hill Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet St. Peters Cemetery

DATE OF BURIAL: Apr 2" 1923

20 UNDERTAKER: Jno. M. Johnson

ADDRESS 1234 Ethington Av.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74362

D74362

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Hart Rodden

(a) RESIDENCE. NO. Ebensburg Pa. ST., 27 WARD. Ebensburg Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? 40 yrs. 6 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Sept 18 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	6	12ds	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) Ebensburg Pa.

PARENTS

10 NAME OF FATHER Mathew Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Catharine Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mt Hope Records (Address) Mt Hope City

15 Filed APR 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from June 29 1920, to March 31, 1923, that I last saw h.r alive on March 30, 1923, and that death occurred, on the date stated above, at 1015 A m.

The CAUSE OF DEATH* was as follows:

Epileptic Mania

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Status Epilepticus

(duration) 1 yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) C. J. Esser, M. D.

3-31 1923 (Address) Mt Hope Retreat, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 2 1923
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH to be plainly written, so that it may be properly classified. PENALTY FOR MAKING FALSE STATEMENTS OR REPORTS. PART RESPONSIBILITY OF UNDERTAKER. See instructions on back of certificates.

TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74363

CERTIFICATE OF DEATH.

D74363

Registered No.....

1-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 5911 Belona Avenue St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME EDITH MILDRED NORRIS

(a) Residence No. 5911 Belona Avenue St., 27 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? 20 yrs. 10 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): May 17 1902

7-AGE. 20 yrs. 10 mos. 13 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer: None

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: T. Ward Norris

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Maryland

12-MAIDEN NAME OF MOTHER: Mabel Foreman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland

14- (Informant) Misses. Foreman (Aunts)
(Address) 5911 Belona Avenue

15- Filed APR 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 30 1923

17- I HEREBY CERTIFY, That I attended deceased from Feby 12 1923 to March 30 1923
that I last saw h[er] alive on March 30 1923
and that death occurred, on the date stated above, at 12.45 P m.
The CAUSE OF DEATH* was as follows:
Typhoid Pneumonia

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. 1 mos. 18 ds.

18-Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan M. D
, 19 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Druid Ridge Cemetery	April 2 1923.

20-UNDERTAKER.	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	108 W. NORTH AVE.

Sp... R.S.—400 Eks.

D74364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74364

CERTIFICATE OF DEATH.

Registered No. 178

1-PLACE OF DEATH
City of BALTIMORE: (No. Southern Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lula M. Taylor

(a) Residence No. 606 W 33rd St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of Late Thomas Taylor / WIFE of Unknown

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.
10-NAME OF FATHER Wm Delhaven
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa
12-MAIDEN NAME OF MOTHER Francis Robinson
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) John E Delhaven
(Address) 704 36th St

15-FILED APR 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 30-1923.

17- I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1923, to March 30, 1923, that I last saw h.. alive on March 30, 1923, and that death occurred, on the date stated above, at 9.15 P.M.

The CAUSE OF DEATH* was as follows:
{ RT. hemiplegia - 3 days
{ Epilepsy, since 18 yrs old
(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary edema
(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Dudley P. Bowe M. D.
, 19 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampstead — DATE OF BURIAL. Apl 2 1923

20-UNDERTAKER, Eckenrode & Son — ADDRESS Chestnut Pl

In placing name, be sure it may be properly deciphered. Erasures will void certificate. See instructions on back of certificate.

Spec.—6-3-19—M. & S.—1000 Bks.

D74365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74365

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Madison ave ST. 14 WARD)

2-FULL NAME Olevia Burch.

(a) RESIDENCE. No. 1615 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johnson J Burch

6 DATE OF BIRTH (month, day, and year) 1853 AUG 27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X	69	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER X Allison

11 BIRTHPLACE OF FATHER (city or town) (State or country) X Penn.

12 MAIDEN NAME OF MOTHER X not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) X West. Va.

14 Informant Charles I Ruby Nephew
(Address) 1615 Madison Ave

15 Filed APR 2 - 1923 . 19 ROBERT R. KRAUTER, Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from March 28th, 1923, to March 31, 1923

that I last saw her alive on March 31 — 1923

and that death occurred, on the date stated above, at 2 P — m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis? Urine, Acidosis

(Signed) Samuel A Bair M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apl 3 1923
20 UNDERTAKER Chenoweth & Son	ADDRESS Chestnut Ave

D74366 HEALTH DEPARTMENT—CITY OF BALTIMORE D74366

CERTIFICATE OF DEATH. 7 31

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2235 Penna. Ave. ST.: 14 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Jackson

(Residence in Baltimore: No. 2235 Penna ave. St.; yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	sing'l

6-DATE OF BIRTH, about (Month) (Day), 1915 (Year)

7-AGE, 8 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Co. Md

PARENTS.

10-NAME OF FATHER. Wm Jackson

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Bell Hall

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Rogers [redacted]

(Address) 2235 Penna. Ave.

15- Filed APR 2 – 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY: (Secondary)

(Duration) yrs. mon. ds.

(Signed) J. J. Hennessy (Coroner.) M. D.

April 2, 1923 (Address) 780 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, West Liberty Howard Co Md

DATE OF BURIAL, Apr. 4, 1923

20-UNDERTAKER James H. Dennis

ADDRESS, 303 Freemont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74367

CERTIFICATE OF DEATH.

161-001

D74367

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2817 Frisby ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Morris

(Residence in Baltimore: No. 2817 Frisby st. St.; ....yrs., ...mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May 31, 1923.
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 2817 Frisby st. Balto. Md.

PARENTS.

10-NAME OF FATHER, Louis L. Morris

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER, Madeline Schlichenmaier

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Madeline Schlichenmaier

(Address) 2817 Frisby st.

15- FILED APR 2 - 1923 191.... ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 1, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 31 1923, to April 1 1923, that I saw him alive on May 31 1923, and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. J. Gillabury M. D.

4/1, 1923 (Address) 815 Cathedral Corner Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Parkwood	4/2, 1923
20-UNDERTAKER W. P. Cook	ADDRESS 502 E North

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74368

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Albion, Cathedral + Read STS. 11th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Forester Nicholson

(a) RESIDENCE. No. Hotel Albion, Cathedral + Read STS. 11th WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Robinson

6 DATE OF BIRTH (month, day, and year) October 9, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker (retired, 39 years)

(b) General nature of industry, business, or establishment in which employed (or employer) Banking

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Isaac Lee Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Caroline Conlz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs E. Carolyn Nicholson
(Address) 301 W. Lanvale St. Balto. Md

15 Filed APR 2 - 1923 ROBERT A. KRAUTEN, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-31, 1923, to 3-31, 1923, that I last saw h.. alive on 3-31, 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

1HR. MYOCARDITIS

(duration) ? yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Ac. myocardial insuffic.

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Dorsey, M. D.

. 19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	4/2/1923

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS Ordway & McCulloh Sts

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1032

D74369

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 Maryland ave ST. 25 WARD)

2-FULL NAME John M Nichols Jr.

(a) RESIDENCE. No. 324 Maryland ave Westport ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phebe Nichols

6 DATE OF BIRTH (month, day, and year) Feb 1/1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	2 mo.	nine	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glassworker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER John M. Nichols Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Emma Shatten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Phebe Nichols (Address) 324 Maryland ave

15 Filed APR 2-1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to April 1, 1923, that I last saw him alive on March 31, 1923, and that death occurred, on the date stated above, at 2.40 p. m.

The CAUSE OF DEATH* was as follows:

Nervol Calculi

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute hepatitis

(duration) one yrs. no mos. 2 ds.

18 Where was disease contracted if not at place of death? Westport

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Examination

(Signed) Raymond Eckard, M. D.

(Address) Oakland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Millville N. J.	April 6 1923

20 UNDERTAKER H. E. Stiles

ADDRESS 820 md ave Westport

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION of certificates.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

160 D74370 HEALTH DEPARTMENT—CITY OF BALTIMORE D74370

CERTIFICATE OF DEATH. 122-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Life

2-FULL NAME Henry Leonard.

(a) RESIDENCE NO. 1515 E. Lombard City St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3, mos. 11, ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~

6 DATE OF BIRTH (month, day, and year) Oct 21, 1861.

7 AGE: 54 Years; 5 Months; 7 Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): " " 040

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: William Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: Anne Lowary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 APR 2 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19 1922 to March 30 1923, that I last saw h[illegible]live on March 31, 1923, and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver (Metastatic Primary)

(duration) yrs. 5 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Blake W Cunningham M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: April 2 1923

20 UNDERTAKER: Richard H. Cumley — ADDRESS: 1108 Guilford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

over

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74371

CERTIFICATE OF DEATH.

100-001

D74371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 Vine St. ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Jones,

(a) RESIDENCE NO. 1040 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Blk	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 10. 23.

7 AGE	Years	Months	Days	If LESS than 1 day, \ hrs. or \ min.
	—	One	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Jno. V. Jones,

11 BIRTHPLACE OF FATHER (city or town) Christfield
(State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Talley.

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant (Address) Jno. V. Jones, 1040 Vine St.

15 Filed APR 2-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31 1923.

17 I HEREBY CERTIFY, That I attended deceased from 3/29 .1923. to 3/31 .1923.

that I last saw her alive on March 30. 1923,

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia,
(Primary.)

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Thos. Corbin, M. D.

3/31. 1923 (Address) 888 N. Lemmond Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL April 2 1923

20 UNDERTAKER Brown & Leland.

ADDRESS 1140 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74372

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 3449 Ash. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Washington Poole

(Residence in Baltimore: No. 3449 Ash. St.; yrs. ..... mos. ..... ds.) 3

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. July (Month) 1 (Day) 1850 (Year)

7-AGE. 72 yrs. 9 mos. — ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tanner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Washington Poole

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Cornelia Davis

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter E Poole
(Address) 3449 Ash St

15-
Filed APR 2 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 1 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Abscess
Tuberculosis of
Septicemia
(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John [illegible] M. D.
(Coroner.)
April 2 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Poplar Spring	April 3 1923
20-UNDERTAKER,	ADDRESS
Jas. R. Wren	Sykesville Md

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Space is provided for this on front of certificate. It is very important. See instructions on back of certificate.

D74373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74373

CERTIFICATE OF DEATH.

3/188-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. W. Md. R.R. Trestle Westport St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harris Hoffman. 18 ----------

(Residence in Baltimore: No. 114 Albemarle St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know. ..... 1.....
(Month) (Day) (Year)

7-AGE, 82 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 86

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Abraham Hoffman

11-BIRTHPLACE OF FATHER, (State or Country). Russia.

12-MAIDEN NAME OF MOTHER, Pearl ---------

13-BIRTHPLACE OF MOTHER, (State or Country). Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Hoffman. (son).

(Address) 2700 Pennsylvania. Ave

15. APR 2 - 1923 192..... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.

Crushed about the chest accidentally struck by engine no. 920 W. Md. R. R.

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt (M. D.)
(Coroner)

April 2 192 3. (Address) 1014 Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Mount Int. Carmel March 2nd 19 23

20-UNDERTAKER. ADDRESS
Jack Krauss, 1439 E. Baltimore St.

THE CAUSE OF DEATH must be stated plainly, so that a Physician is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74374

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 W. Saratoga ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arominta Harris

(a) RESIDENCE No. 1608 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James Harris

6 DATE OF BIRTH (month, day, and year) April 15, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Long Green Md.

PARENTS

10 NAME OF FATHER ? Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Long Green Md.

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Long Green

14 Informant Howard R. Harris (Son)
(Address) 1608 W. Saratoga St

15 APR 2-1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations on back of certificates. TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March, 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18th, 19 23 to March 30th. 19 23.

that I last saw her alive on March 29th. 1923,

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Brooken Compensation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter S. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hamilton Catonsville Md

DATE OF BURIAL Apl 2 1923

20 UNDERTAKER John H Owens

ADDRESS 533 Dolphin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74375

CERTIFICATE OF DEATH.

11th

D74375

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 801 Edmondson Ave ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Anna E. Wells

(Residence in Baltimore: No. 801 Edmondson Ave. St.; 33 yrs., 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	[illegible]

6-DATE OF BIRTH, Mar. 27, 1889 (Month) (Day) (Year)

7-AGE	If LESS than 1 day, ...hrs. or.....min.?
33 yrs. 4 mos. 3 ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Amelia Wachenfeld

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Jones

(Address) 1716 Orleans St

15- Filed APR 2 - 1923, 191.. ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held no inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. gastro enteritis

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) ac. Dilatation of Stomach

(Duration) ..... yrs. ..... mos. 1/2 ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

April 1, 1923 (Address) 502 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Dulaney's DATE OF BURIAL, April 2nd, 1923

20-UNDERTAKER F. B. Shipley ADDRESS 2236 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74376

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. D74376

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto A. Wenzing

(a) RESIDENCE NO. 2642 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Wenzing

6 DATE OF BIRTH (month, day, and year) June 30, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 109

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk. Unknown

12 MAIDEN NAME OF MOTHER Unk Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk Unknown

14 Informant Mrs Carrie Wenzing

(Address) 2642 Harlem Ave

15 Filed APR 2 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to March 30, 1923,

that I last saw him alive on March 30, 1923,

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Moses Paulson M.D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL April 2 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74377

D74377

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 Shields Alley ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Blackston

(a) RESIDENCE NO. 1534 Shields ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, ~~or divorced~~ (or) WIFE of Robert Blackston

6 DATE OF BIRTH (month, day, and year) ~~March~~ 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 70

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Charlotte Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant (Address) Rose Jervis 1534 Shields

15 APR 2-1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to May 30, 1923, that I last saw h[illegible] alive on May 29, 1923, and that death occurred, on the date stated above, at 7.55 A. m

The CAUSE OF DEATH* was as follows:

Cancer of Breast (Sept)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur Frey, M. D.

5/30, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lookout — DATE OF BURIAL 6-1-23

20 UNDERTAKER Edward Hensley — ADDRESS 1578 Mt Holly

IMPORTANT—Information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74378

CERTIFICATE OF DEATH.

74-001

D74378

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 913 Sr. Barnabas Court St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Cornish

(Residence in Baltimore: No. 913 Sr. Barnabas Court. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female | 4-COLOR OR RACE, colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed

6-DATE OF BIRTH, August (Month) ..... (Day), 1867 (Year)

7-AGE, 56 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Hopkins

(Address) 1433 Lemmon Ave.

15- Filed APR 2 - 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquisition (Inquest, autopsy or inquiry) and that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic kidney disease

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)

March 31 1923 (Address) 2 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Pikesville Md | DATE OF BURIAL, 4-2-, 1923

20-UNDERTAKER David Carton | ADDRESS 916 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D74379

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Rutland Ave ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Teresa Augusta Jones

(a) RESIDENCE NO. 1625 Rutland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Jones

6 DATE OF BIRTH (month, day, and year): Sept 4 1859

7 AGE: Years 63 Months 7 Days 27 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: John Field

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Jones

(Address) 1115 N Mosher

15 Filed APR 2-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 31 1923

17

I HEREBY CERTIFY, That I attended deceased from 1910, 19.... to Mar 31, 1923.

that I last saw h.. alive on Mar 30, 1923,

and that death occurred, on the date stated above, at 12.26 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis Agitans

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm T Watson, M. D.

3/31, 1923 (Address) 21 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 4/3/23

UNDERTAKER: Enoch Fowler — ADDRESS: Fulton & Fayette

Srec—12-23-21—E.B.R.S.—400 Bks.

D74380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D74380

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Henderson

(a) Residence No. 704 St. Paul St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ? ? 1857

7-AGE 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 640

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER John Alexander

11-BIRTHPLACE (OF FATHER (city or town) (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Cyrenia [illegible] Rousseau

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), S C

14- (Informant) Next Friend

(Address) Mercy Hospital

15- Filed APR 2 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

In plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 1 '23

I HEREBY CERTIFY, That I attended deceased from March 28 19 23 to April 1 19 23

that I last saw h[illegible] alive on March 31 19 23

and that death occurred, on the date stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Acute

(Duration) 3? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Smear

(Signed) A. J. Pinsoneault M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cem	4/2/23

20-UNDERTAKER.	ADDRESS.
Jno. A. Farley Sutton & Fayette	

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74381

D74381

Registered No. 96

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Boleska Dworecka

(a) Residence No. 516 S. Wolfe St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Martin ? Dworecki

6-DATE OF BIRTH (month, day and year) 1863

7-AGE.	If LESS than 1 day.
59 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). 37

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14-(Informant) Municipal Hospital Record

(Address)

15-Filed APR 2 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

In plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from November 22, 19 22 to March 28, 19 23

that I last saw her alive on March 28, 19 23

and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Strat Faciens

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) aurinea fibrication

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Mackay M. D.

3-29-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus Bm.	April 3, 19 23
20-UNDERTAKER.	ADDRESS
W. F. Sadowski	705 S. Ann St.

Spec.—1-10-21—M&T—1500 Bks.

D74382 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74382

Lethal Weight & Pillow Co 74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fulton Court Apts ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lizzie Hawkins

(a) RESIDENCE NO. Fulton Court Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Alexander Hawkins

6 DATE OF BIRTH (month, day, and year) June 12-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Edward Wynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va

12 MAIDEN NAME OF MOTHER Lucy Wynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant Mrs. E. Hawkins (Address) 1 Fulton Court

15 Filed APR 2-1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1 1923

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1923, to March 31, 1923, that I last saw h[illegible] alive on March 31, 1923, and that death occurred, on the date stated above, at 3.05 p. m. The CAUSE OF DEATH was as follows:

Pneumonia preceding Apoplexy.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of

Was there an autopsy? X

What test confirmed diagnosis?

(Signed) Edwin Murray, M. D.

April 2 1923 (Address) 1221 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Apr 3-1923

20 UNDERTAKER Tolson & Mott ADDRESS 1231 W. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

Lily M Hunt ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74383

CERTIFICATE OF DEATH.

100-001

D74383

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5218 St Charles ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lily M Hunt

(a) RESIDENCE. No. 5218 St Charles ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan 27 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 5218 St Charles ave Arlington md

PARENTS

10 NAME OF FATHER Wayne E. Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto co md

12 MAIDEN NAME OF MOTHER Martha Triplett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto co md

14 Informant (Address) Wayne E. Hunt 5218 St Charles ave

15 Filed APR 2 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from March 21st, 1923, to April 1st, 1923, that I last saw her alive on March 31st, 1923, and that death occurred, on the date stated above, at 5, A m.

The CAUSE OF DEATH* was as follows:

Bronchi Pneumonia

(duration) X yrs. X mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) X yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What (est confirmed diagnosis? Bronchi Pneumonia

(Signed) L. Frank Schuller M. D.

(Address) Reisterstown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	April 3 1923
20 UNDERTAKER	ADDRESS
J. F. Eline	Reisterstown Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 2 [illegible]

Burial Permit Clerk. [illegible] mo

See Card attached

D74384 HEALTH DEPARTMENT—CITY OF BALTIMORE 90. D74384

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1028 N. Mount St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick E. Tierney

(Residence in Baltimore: No. 1028 N. Mount St. St.; yrs. 73 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. November (Month) 28th (Day) 1853 (Year)

7-AGE. 69 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Police Sergt.

9-BIRTHPLACE, (State or Country), Canada

PARENTS.

10-NAME OF FATHER. Wm. Tierney

11-BIRTHPLACE OF FATHER, (State or Country), Ireland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Tierney

(Address) 1028 N. Mount St.

15- Filed APR 2 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 1st (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Apr. 2nd 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem	Apr 4" 1923
20-UNDERTAKER.	ADDRESS
Jos L. B. Cook	1003 N Gilmor St

is very important. See instructions on back of certificate.

Burwick, daughter of Patrick & Tierney (deceased) has appeared before me and stated that the age given to me for the death certificate was wrong. Her real age was seventy at the time of his death.

J. T. Hennessy
Coroner

May 19/1913.

Statem
occupatio
healthfulr
The ques
respecti
word or
e. g., *Fa*
Architect,
Stationar
pecially
to know
nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

oma, etc., of
is less definite;
nt neoplasms);
valvular heart
, etc. The con-
affection need
mple: *Measles*
Bronchopneu-
r report mere
such as "As-
tomatic), "At-
rophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

D74385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74385

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Union Memorial Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander George Bayliss

(Residence in Baltimore: No. 2727 W. North Ave. St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. April (Month) 10th (Day) 1911 (Year)

7-AGE.	If LESS than 1 day,
11 yrs. 11 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George F. Bayliss

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Bessie May Baker

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bessie May Baker

(Address) 2727 W. North Ave.

15- Filed APR 2 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 31st (Day), 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

about 1 hr.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) automobile accident

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Apr. 2" 192 3 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	April 2" 1923

20-UNDERTAKER.	ADDRESS.
Joseph B. Cook	1003 N. Balto St

THE CAUSE OF DEATH must be stated, so that a correct opinion may be formed as to whether the disease was communicable, or the death resulted from accident, violence, or criminal act. This certificate is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74386

CERTIFICATE OF DEATH. 122-002

D74386

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., WARD)

2-FULL NAME Frank Stricker (Strejcek)

(a) RESIDENCE NO. 817 Shuter ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Strejcek

6 DATE OF BIRTH (month, day, and year) April 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Strejcek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Emma Hrazdira

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Emma Strejcek

(Address) 819 n Shuter st

15 Filed APR 2 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 5, 1923, to Mch 30, 1923, that I last saw him alive on Mch 30, 1923, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(Varices of stomach with Rupture)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cirhosis of Liver & Ascites

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Leonard A Greenbaum M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apl 3 1923

20 UNDERTAKER Frank Ewaschutz

ADDRESS 1906 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74387. HEALTH DEPARTMENT—CITY OF BALTIMORE D74387

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Hilltop av ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V. Phillips

(a) RESIDENCE. NO. 2223 Hilltop av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Phillips

6 DATE OF BIRTH (month, day, and year) Nov. 23 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	60	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Bachlor C. Skinner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Lard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James A. Phillips (Address) 2223 Hilltop Ave

15 Filed ..., 19... Registrar

R 2-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to April 1, 1923, that I last saw h... alive on April 1, 1923, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Cerebral

(duration) Years Months Days

CONTRIBUTORY (Secondary) Endocarditis Chronic

(duration) 2 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Estelle Lutz 6 M. D.

4/2/ 1923 (Address) 215 S Hilltop av

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Apr. 4 1923

20 UNDERTAKER George L. Schwab ADDRESS 301 Fulton Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74388

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 Frederick St. 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Haven

(a) RESIDENCE. NO. 2029 Frederick St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of April 30—1852

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Haven.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Duffy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Harry Haven.

(Address) 2029 Frederick ave.

15 F[illegible] Robert P. Harrison, Registrar

R 2-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct-20, 1922, to Mar 30, 1923, that I last saw h— alive on Mar 29, 1923, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. ! ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical finding

(Signed) James H Duffy M. D.

4/2, 1923 (Address) 1729 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	April 3 1923
20 UNDERTAKER	ADDRESS
George L. Schwab	2101 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74389

CERTIFICATE OF DEATH.

100-00

D74389

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin H. Wren.

(a) RESIDENCE NO. 2027 Booth St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Wren

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of Industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Allen Wren

11 BIRTHPLACE OF FATHER (city or town) Ohio (State or country)

12 MAIDEN NAME OF MOTHER Catherine Frank

13 BIRTHPLACE OF MOTHER (city or town) Ohio (State or country)

14 Informant Mrs. Ella Wren (Address) 2027 Booth St

15 Filed 4-2-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/12, 1923, to 4/1, 1923, that I last saw him alive on 4/1, 1923, and that death occurred, on the date stated above, at 4-10 A.m.

The CAUSE OF DEATH* was as follows:

Lung Abscess.

Tbc. T-13

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes no Date of 3/30/23.

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Thos Ferrand M.D.

, 19 (Address) Union Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Apr 3 1923

20 UNDERTAKER John J Corcoran & Son ADDRESS 901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74390 HEALTH DEPARTMENT—CITY OF BALTIMORE D74390

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Bartlett Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite Humphrey

(a) RESIDENCE NO. 622 Bartlett Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Timothy J. Humphrey

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ..

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) County Tyrone Ireland

PARENTS

10 NAME OF FATHER John O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Fanny Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Phillip Humphrey

(Address) 622 Bartlett Ave

15 Filed 1923 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from March 29th, 1923 to April 1st, 1923.

that I last saw her alive on April 1st, 1923

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia.

(duration) yrs. mos. X ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Lang Stroy Price M. D.

4/1/1923 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL April 4 1923

20 UNDERTAKER E. A. Wendefeld Jr — ADDRESS 501 E 22 St

*CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-1923

Spec.—1-10-21—M&T—1500 Bks.

D74391 57

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74391

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Banks.

(a) RESIDENCE No. 1433 E. Monument St. City; WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (OR) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. ? 1919.

7 AGE: Years 3 Months 6 Days ? If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): (-)

(c) Name of employer: (-)

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Allen Banks.

11 BIRTHPLACE OF FATHER (city or town) (State or country): (-) Va

12 MAIDEN NAME OF MOTHER Clara Banks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): (-) Virginia

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Casualty

15 Filed Apr 2 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1923, to April 2, 1923, that I last saw him alive on April 2, 1923, and that death occurred, on the date stated above, at 12 00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Nasal Diphtheria + Cervical adenitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem

DATE OF BURIAL: Apr. 3 1923

20 UNDERTAKER: Edw Bryan

ADDRESS: 1631 Orleans Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74392 HEALTH DEPARTMENT—CITY OF BALTIMORE D74392

CERTIFICATE OF DEATH.

REGISTERED NO. 5-7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1740 E. North Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Frances Thompson

(a) RESIDENCE. No. 1740 E. North Ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Charles M. Thompson

6 DATE OF BIRTH (month, day, and year) Mch 10-1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	x	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Jesse McCauley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Maryland.

12 MAIDEN NAME OF MOTHER Clara Deacon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Charley M Thompson

(Address) 1740 E North Ave

15 Filed APR 2-1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1923, to Mar 31, 1923.

that I last saw her alive on Mar 30, 1923.

and that death occurred, on the date stated above, at 9.45A m.

The CAUSE OF DEATH* was as follows:

Diabetes

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) E. B. Britton M. D.

3-31. 1923 (Address) 1711 E Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	4/3/23
20 UNDERTAKER	ADDRESS
A E Hughes & Son	1 E Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Burial Permit Clerk.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74393

CERTIFICATE OF DEATH.

114

D74393

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 E. 25th St, ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E.C. Copes.

(a) RESIDENCE NO. 315 E. 25th, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 23, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	40	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George L.F. Copes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ellen F. Vickers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Mary B. Robinson (sister).

(Address) 315 E. 25th Street.

15 Filed Mar. 31 1923 Robert P. Harrison, Registrar

Burial Permit Clerk?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to March 31, 1923.

that I last saw her alive on March 30, 1923,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Ulceration.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? No. Date of ---------

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M. Reinhardt, M. D.

Mar. 31 1923 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL 4/1/23

20 UNDERTAKER N. E. Snyder ADDRESS 424 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16 D74394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74394

CERTIFICATE OF DEATH. X 135

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME John R. Blake

(a) RESIDENCE No. Greenwood S.C. ST., ... WARD Greenwood S.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. — ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mrs. Blanche Blake

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: Milton ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to April 7, 1923, that I last saw him alive on April 7, 1923, and that death occurred, on the date stated above, at 10-10 A. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 3 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

~~Cancer~~ (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? .....

(Signed) Eugene C. Shaw M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenwood S. C.

DATE OF BURIAL 4/8/23 19

20 UNDERTAKER: W. E. Hughes Inc.

ADDRESS 1 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

- 1923

Spec.—1-10-21—M&T—1500 Bks.

Permission granted, To Reproduce. Minnie 4/2/23.
Dr Frederick Stumpf asst Com.

D74395 HEALTH DEPARTMENT—CITY OF BALTIMORE D74395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Madison Ave ST., 13 WARD) REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Leo Dailey - Jr.

(a) RESIDENCE No. 2211 Madison Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 25-1923.

7 AGE	Years	Months	Days	If LESS than 1 day 16 hrs. or 30 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Richard Leo Dailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canton, Mass.

12 MAIDEN NAME OF MOTHER Nellie Eliz. Carson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburgh Pa.

14 Informant Mother of baby
(Address) same.

15 Robert F. Harrison, 19
Registrar

2-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26 1923.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25, 1923, to Mar. 26, 1923, that I last saw him alive on Mar. 26, 1923, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Bleeding from cord.

(duration) yrs. mos. 6 hrs dys

CONTRIBUTORY (Secondary) Hemophilia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. W. Cloverdale. DATE OF BURIAL Apl 3. 1923

20 UNDERTAKER John A Mitchell ADDRESS 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74396

CERTIFICATE OF DEATH.

31

D74396

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2522 E Biddle ST., 8 WARD)

2-FULL NAME Mous Bleck.

(a) RESIDENCE NO. 2522 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Bleck.

6 DATE OF BIRTH (month, day, and year) Nov. 17-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	57	4	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman. 066

(b) General nature of industry, business, or establishment in which employed (or employer) Hebe Clothing Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leopold Bleck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) austria Hungary

12 MAIDEN NAME OF MOTHER Antonette Wernaschuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) austria Hungary

14 Informant (Address) Nannie Bleck 2522 E Biddle St.

15 Filed ..... 19.... Robert F. Harrison, Burial Permit Clerk. Registrar

2-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1923

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1920 to April 2, 1923, that I last saw him alive on March 31, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Hemmorrhage. 4 hours (duration) ... yrs. ... mos.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 2 yrs. 9 mos. 17 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? X Ray.

(Signed) Thos Fr Stevens, M. D.

4/2, 1923 (Address) 2918 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL April 4 1923

20 UNDERTAKER Wm Cook. ADDRESS 1021 N Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D74397

REGISTERED NO. .....

(If death occurred in a bospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 S Chapel ST., V WARD)

2-FULL NAME Pelagia Marski

(a) RESIDENCE NO. 404 S Chapel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 12 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michal Marski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna, Nadolny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Michal Marski
(Address) 404 S Chapel St.

15 R 2 - 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 2, 1923, that I last saw h[illegible] alive on " 1, 1923 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs & Symptoms

(Signed) [illegible], M. D.

4/2/1923 (Address) 403 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: April 3 1923

20 UNDERTAKER: JOHN M. WEBER — ADDRESS: 1803 BANK ST.

IMPORTANT—Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74398

CERTIFICATE OF DEATH. 101-001

D74398

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2419 Foster ave ST., 1 WARD)

2-FULL NAME Mary Goralski

(a) RESIDENCE NO. 2419 Foster ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Goralski

6 DATE OF BIRTH (month, day, and year) Oct. 21 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	40	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Poland~~ Cleveland Ohio

PARENTS

10 NAME OF FATHER John Dolisz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Cath. Konieczny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John L. Goralski (Address) 2419 Foster ave

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1923, to April 2, 1923, that I last saw ~~her~~ alive on " 1, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Physical Signs

(Signed) C. D. Bruer, M. D.

4/2/23 (Address) 405 S Pat PK Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ~~Holy Rosary~~ Sacred Heart — DATE OF BURIAL April 5 1923

20 UNDERTAKER John M. Weber — ADDRESS 1803 Bank st.

R 2-1923

IMPORTANT—Before signing, be sure that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74399

D74399

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 Fleet ST., 1 WARD)

2-FULL NAME Wladislaus Kozlakowski

(a) RESIDENCE NO. 2124 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wladislaus Kozlakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Chmiel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wladislaus Kozlakowski
(Address) 2124 Fleet St.

15 4-2-1923 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923. to April 1. 1923.

that I last saw him alive on April 1. 1923

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

John Pneumonia,

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William A. Powers M. D.

4-2-23 (Address) 801 N Chester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 3 1923
20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank st.

Burial Permit Clerk.

IMPORTANT—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74400

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH St Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE, (No. ... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Mitchell

(a) RESIDENCE NO. 418 N Strieker WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ alice Wheeler Mitchell

6 DATE OF BIRTH (month, day, and year) Jan. 6. 1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55	2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wholesale Fish
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer 045
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS
10 NAME OF FATHER John Mitchell
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.
12 MAIDEN NAME OF MOTHER Gertrude Lunebaugh
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Mitchell 418 N. Strieker St.

15 2-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 28. 1923. to Mch 30. 1923.
that I last saw h[illegible] alive on Mch 30 1923
and that death occurred, on the date stated above, at 9 30 p. m.
The CAUSE OF DEATH* was as follows:
Myocardial Insuff.

(duration) - yrs. mos ds.
CONTRIBUTORY (Secondary) Carcinoma duodenum
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) S W Bowers M. D.
(Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL april 3 1923

20 UNDERTAKER Margaret L. Flynn — ADDRESS 1422 Light

BEFORE signing, be sure you have given answer to every question. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74401

Spec. 6-9-19—H. P. Co.—1000 Blks.

D74401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Harford Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Freeman

(a) RESIDENCE. No. 809 Harford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Clarence N. Freeman
(Address) [illegible]

15 Filed APR 3 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1923, to March 29, 1923, that I last saw h alive on March 29, 1923, and that death occurred, on the date stated above, at 6 [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic colitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. G. Hornstein, M. D.

4/2, 1923 (Address) [illegible] Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem.	Apr. 4 1923
20 UNDERTAKER Chris. H. Johnson	ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CHASE

Spec.—1-10-21 M&T 1500 Bks.

D74402

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001

D74402

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Mulliken ST., 6 WARD)

2-FULL NAME William H. Chase.

(a) RESIDENCE NO. 1620 Mulliken ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jennie Chase

6 DATE OF BIRTH (month, day, and year) Jan 3-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles H. Chase

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Isabella Cromwell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Jennie Chase
(Address) 1620 Mulliken St.

APR 3 - 1923

Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/3/23, 19..., to 3/31/23, 19 23.

that I last saw him alive on March 31, 19 23.

and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Senile infection.
from auricular abscess.
about 2 wks

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. Field Boyd M. D.

4/4/23, 19 (Address) 4701 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Apr. 4 19 23

20 UNDERTAKER Chas. H. Johnson ADDRESS 4467 N Carolina

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can bo ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriago, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossiblo to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of causo of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74403

CERTIFICATE OF DEATH.

45 D74403

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4621 Pimlico Rd ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Stern

(a) RESIDENCE No. 4621 Pimlico ST. Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Stern

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Commercial Job

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Meyer Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marion Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bernard Stern

(Address) 4621 Pimlico Rd

15 APR 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 Apl 1923

17 I HEREBY CERTIFY, That I attended deceased from 2 Apl, 1923, to 2 Apl, 1923, that I last saw him alive on 2 Apl, 1923, and that death occurred, on the date stated above, at 3 PM

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yrs. 0 mos 2 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) - yrs. - mos. 5 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Harry W Byers M. D.

, 19 (Address) 749 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem

DATE OF BURIAL 4/4 1923

20 UNDERTAKER J. Ahrens Co

ADDRESS 1611 Madison

Spec.—1-10-21—M&T—1500 Bks.

D74404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Stern

(a) RESIDENCE NO. 2009 Madison Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Orrin Stern

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Solomon Lehrer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fanny Jowtow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore

15 Filed APR 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17

I HEREBY CERTIFY, That I attended deceased from 3-20, 1923, to 3-31, 1923

that I last saw h[illegible] alive on March 31, 1923

and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Cardiac Valvular Disease

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leonard H Greenbaum M. D.

3/31, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hessing Rm

DATE OF BURIAL 4/3 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

IMPORTANT—Should be carefully applied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D74405

CERTIFICATE OF DEATH. 100-001 D74405

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E Monument ST. 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl abelson

(a) RESIDENCE NO. 505 N. Bries ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26, 1923

7 AGE: Years | Months | Days: 5 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Louis Abelson

11 BIRTHPLACE OF FATHER (city or town) Russia. (State or country)

12 MAIDEN NAME OF MOTHER Sophie Klitzner

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant (Address) Hosp

15 Filed APR 3 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to March 31, 1923,

that I last saw her alive on March 31, 1923,

and that death occurred, on the date stated above, at 6 00 9. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia terminal

(duration) ....yrs. ....mos 1 ds.

CONTRIBUTORY (Secondary) Foetal malnutrition

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edelstein, M. D.

March 31, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL 4/3 1923

20 UNDERTAKER: Jack Levis

ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74406

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002 D74406

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2002 Presbury Street 15 St.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chia Steistadt

(Residence in Baltimore: No. 2002 Presbury Street St.; 32 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (If *rite* the word): Widow

6-DATE OF BIRTH: Unknown (Month) ....., 1856 (Year)

7-AGE: 67 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): /

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Lewis

(Address) 1439 E Baltimore Street

APR 3 - 1923

15-Filed ....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April 1st, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 28 '23, to April 1st/23, that I saw h er alive on April 1st, 1923, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows: Uremia

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY): Arteriosclerosis

(Duration) 9 yrs. ..... mos. ..... ds.

(Signed) Harris Goldman M. D.

April 1/23 (Address) 18/0 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Rehrer-Herring Fun — DATE OF BURIAL: 4-4-23

20-UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74407

101-08

D74407

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 St Mathew St., 5 WARD)

2-FULL NAME Rose Bardoff

(a) RESIDENCE NO. 1200 St Mathew St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Solomon~~ Charles R Bardoff

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Pinkam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pinkam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto St

15 Filed APR 3 1923 ROBERT R. KRAUSER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Febr, 1923, to April 1, 1923, that I last saw h[illegible] alive on March 31, 1923, and that death occurred, on the date stated above, at 1.09 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Hypercarditis (mitral & aortic manufficency)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic congestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Gross

(Signed) Nathaniel Barb. M. D.

19 (Address) 2731 Parkwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kehrer Cem York Rd

DATE OF BURIAL 4/3 1923

20 UNDERTAKER Jack Lewis

ADDRESS 439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-081

D74408

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1310 Edmondson Ave ST., 16 WARD)

2-FULL NAME Jacob Posner

(a) RESIDENCE NO. 1310 Edmondson Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Posner

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor 880

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Posner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E Balto

15 APR 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 — 1 1923

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to April 1, 1923, that I last saw him alive on April 1, 1923, and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage
Right Hemiplegia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) arterio sclerosis Hypertension

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Examination

(Signed) Joseph Epstein M. D.

April 2 (Address) 1510 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Wilson Cemetery

DATE OF BURIAL 4/3 1923

20 UNDERTAKER Jack Levis 1439 E Balto

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74409 161-001 D74409

D74409

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Cumberland ST., 15 WARD)

2-FULL NAME Margaret Dorothy Braden

(a) RESIDENCE NO. 703 Cumberland ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Wht	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Mch 23/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles Braden

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Virgil. Bull

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country)

14 Informant Charles Braden (Address) 703 Cumberland St

15 APR 3-1923 File 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 20, 1923, to Apr. 14, 1923, that I last saw h.. alive on Apr. 14, 1923, and that death occurred, on the date stated above, at 1050 A m.

The CAUSE OF DEATH* was as follows:

Toxemia 2nd to fetus Prematurely

(duration) . . yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Visible

(Signed) Edw Smith M. D.

4/1, 1923 (Address) 1605 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 4/2 1923

20 UNDERTAKER Martin Luskey & Son — ADDRESS 1827 W North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Inf. REGISTERED NO.

CITY OF BALTIMORE: (No. 126 N. Broadway ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Thomas B. Burch

(a) RESIDENCE NO. 1712 St. Paul St. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Louise Regester

6 DATE OF BIRTH (month, day, and year) April 2, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	66	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 9

(c) Name of employer Merchants National Bank

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas B. Burch

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria Everett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Clara L. Burch

(Address) 1712 St. Paul Street

15 Filed APR 3 - 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1923

17

I HEREBY CERTIFY, That I attended deceased from March 25 , 1923 , to April 2 , 1923 ,

that I last saw h-- alive on April 2 , 1923 ,

and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) -- yrs. -- mos -- ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis - Hypertension

Chronic Nephritis (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard G. Coblentz , M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/4 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec—12-23-21—E.B.R.S.—400 Bks.

D74411

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74411

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

Registered No. 44

City of BALTIMORE: (No. ..... St. 6 Ward)

2-FULL NAME John Kenny (Kuny)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 22 Lakewood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Corrie Kuny

6-DATE OF BIRTH (month, day and year) May 18 1873

7-AGE, 49 yrs. 10 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Kuntz

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Margaret Grock

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country),

14. (Informant) Mrs Corrie Kuny

(Address) 22 N. Lakewood ave

15. Filed APR 3 - 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 1 '23

I HEREBY CERTIFY, That I attended deceased from March 23 1923 to April 1 1923

that I last saw h[illegible] alive on April 1 1923

and that death occurred, on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus.

(Duration) ? yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cachexia.

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Gastrostomy

Did an operation precede death? Yes. Date of 3-24-23

Was there an autopsy? No.

What test confirmed diagnosis? Path. & oesophagus

(Signed) D J Swearingen M. D.

, 19 (Address) Mercy Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. April 4th 1923

20-UNDERTAKER. George Schilling & Sons

ADDRESS 1126 E Monument st

In plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D74412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74412

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 10 Ward) 129

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Peter Repson
808 N. Central Ave

(Residence in Baltimore: No..... St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the Word.)
male	white	Widower

6-DATE OF BIRTH. July 4/1845 (Month) (Day) (Year)

7-AGE. 77 yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Former
(b) General nature of industry, business, or establishment in which employed (or employer)..... ship carpenter

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Henry Repson

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Neuport

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)..... Henry A. Repson
(Address)..... 808 N. Central Ave

15- APR 3 - 1923 192.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Asthenia
(Duration) .....yrs.....mos.....ds.
CONTRIBUTORY (Secondary) Chronic Nephritis-arterio Sclerosis (Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner.)
4/2/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	April 3rd 1923
20-UNDERTAKER.	ADDRESS
George Schilling & Sons	1126 E. Monument st

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74413

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3829 Hickory Ave (St.) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Harris

(a) RESIDENCE NO. 3829 Hickory Ave (St.) 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W Harris

6 DATE OF BIRTH (month, day, and year) Sept 29 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
64	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

637

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Peter Hoover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Geo W Harris

(Address) 3829 Hickory Ave

15 Filed APR 3 – 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1923 to April 1, 1923.

that I last saw h alive on April 1, 1923,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ascites - Pleurisy (R)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry C Flynn M. D.

Apl 7, 1923 (Address) 3640 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Apl 4 1923
20 UNDERTAKER	ADDRESS
Ehrenwerth Son	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74414

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74414

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5233 Linden Heights Ave ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kunigunda Ketz

(a) RESIDENCE NO. 5233 Linden Heights Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Ketz

6 DATE OF BIRTH (month, day, and year) April 8, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	82	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Knorr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. H. Sommerkorck
(Address) 5233 Linden Heights Ave

15 Date APR 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to April 1, 1923, that I last saw h-r alive on March 31, 1923, and that death occurred, on the date stated above, at 345 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia (duration) ... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No Physical

What test confirmed diagnosis? .....

(Signed) Walter S Hublitt, M. D.

Apr 3, 1923 (Address) 2220 Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Cem.	April 3 1923
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Lexington St.

IMPORTANT SHOULD BE CAREFULLY ANSWERED. Exact statement of OCCUPATION may be properly classified. It may be necessary that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec. 6-3-19—H. P. Co.—1000 Bks.

D74415 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-002 D74415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Brice St.: 16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Ball

(a) RESIDENCE. No. 811 N Brice St., 16 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ball

6 DATE OF BIRTH (month, day, and year) 5-27-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	76	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Bessie Ellis 811 N Brice St.

15 Filed APR 3-1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1923, to April 2nd, 1923, that I last saw her alive on April 1st, 1923, and that death occurred, on the date stated above, at 5:15 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Odema of Lungs

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Woolery, M. D.

(Address) 1400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 5 1923

20 UNDERTAKER William Lee Sons & Walter

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74416

CERTIFICATE OF DEATH.

129 D74416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 Milliman ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Planner Jones

(a) RESIDENCE NO. 2332 Milliman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mary Jones

6 DATE OF BIRTH (month, day, and year): Apr 12-42

7 AGE: Years 80 | Months 11 | Days 19 | If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Painter 950

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Harvey Jones

(Address): 2332 Millimans St

15 APR 3-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/1-1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 30, 1923, to April 1, 1923, that I last saw him alive on April 1, 1923, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan B Lemmon, M. D.

4/3, 1923 (Address) 716 W Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 4/4 1923

20 UNDERTAKER: Philip Herwig

ADDRESS: 2016 Orleans

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D74417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D74417

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Maderia ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred M. Picker

(a) RESIDENCE No. 225 N. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 22-20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	2.	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER Wm G. Picker

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER Theresa A. Fuchs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Mrs G. Picker

(Address) 225 N. Maderia St.

15 Filed Apr 3 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 15, 1923, to Mch. 31, 1923, that I last saw h alive on Mch. 31, 1923 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. O. Athey, M. D.

(Address) 2004 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 4/3 1923

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Bdge.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74418

CERTIFICATE OF DEATH.

57 D74418

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 N. Kenwood Ave WARD)

2-FULL NAME Wm E. E. Knight

(a) RESIDENCE NO. 120 N. Kenwood Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25-97

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Invalid

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Wm E. D. Knight

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Jannie M. Elton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Wm E. D. Knight
(Address) 120 N. Kenwood

15 Filed APR 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 28, 1923 to April 1, 1923, that I last saw h w alive on April 1, 1923, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Emia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan B Lemmon, M. D.

4/3/, 1923 (Address) Alan B Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 4/4 1923

20 UNDERTAKER Philip Henrig — ADDRESS 2016 Orleans

Exact statement of OCCUPATION should be carefully supplied. Avoid terms so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D74419

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74419

CERTIFICATE OF DEATH.

23 24 161-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Chas. M. Hamlen-Charlotte Hamlen

(Residence in Baltimore: No. 1720 Light St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 29/23 1.....
(Month) (Day) (Year)

7-AGE. .....yrs. .....mos. 4 ds. | If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). MD.

PARENTS.

10-NAME OF FATHER. John Hamlen

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Helga Larsen

13-BIRTHPLACE OF MOTHER, (State or Country). Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hamlen

(Address) 1720 Light St

15-

Filed APR 3-1923 19.. ROBERT A. KRAUTER Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 2/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(6 1/2 to 7 months gestation)

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (Autopsy at Hospital)

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. H. Collins M. D.
(Coroner.)

4/2/23 19.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill Cem. | DATE OF BURIAL. April 3 1923

20-UNDERTAKER. Josiah Syfer | ADDRESS 160 W. North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74420

CERTIFICATE OF DEATH.

91-00 D74420

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 207 Aisquith St.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmonia Hinfrey

(a) RESIDENCE. No. 207 Aisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced BUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Interment (Address) Wm. H. Case & Son 1400 Mosher

15 Filed ..., 19 ...

Registrar
ROBERT R. KRAUTER,
Burial Permit Clerk.

APR 3 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Mar 31, 1923, that I last saw h alive on Mar. 31, 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

4-3-1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Apr 3 1923
20 UNDERTAKER	ADDRESS
Wm. H. Case & Son	1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74421

CERTIFICATE OF DEATH.

202

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Herman Kamp.

(Residence in Baltimore: No. 737 S. Potomac. St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, September (Month) 1875 (Day) 1 (Year)

7-AGE.	If LESS than 1 day,
47 yrs. 6 mos. ---- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)..... Prudential Oil Co.

9-BIRTHPLACE, (State or Country). Germany.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda Kamp. (wife)

(Address) 737 S. Potomac St.

15-

Filed ..... 192 ROBERT R. KRAUTER, Registrar.

APR 3 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31st. 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration of the Intestines,
Crushed by accidental fall of a telephone pole.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto H. Leonhardt (Coroner.)

Apl 3 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? Prudential Oil Co, Fairfield 3/30/23.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	April 4 1923

20-UNDERTAKER.	ADDRESS
Lilly + Zeiler	408 S. Mosher St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74422

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 N.Carrollton Ave ST., 16 WARD)

REGISTERED NO. 52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Grace Bell

(a) RESIDENCE NO. 636 N.Carrollton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard A.Bell

6 DATE OF BIRTH (month, day, and year) Aug.10 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): House-work

(c) Name of employer: At home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Wm.Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Snow Hill Md.

12 MAIDEN NAME OF MOTHER Esther Aydelott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Miss Clara Evans 1836 N.Carrollton Ave.

APR 3-1923 Filed 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to March 31, 1922, that I last saw h alive on March 31, 1922, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Septicemia.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mult. fib. Arteriosclerosis

(duration) 18 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

, 19 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 4 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74423

CERTIFICATE OF DEATH.

90 D74423

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Oak Place St. Guilford 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... William A. Dickey

(a) Residence No. Oak Place St. Guilford St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 27 1854

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm H. Dickey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Agnes Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).....

14- (Informant) Wm A. Dickey Jr

(Address) Old Frederick Rd

15- Filed APR 3 - 1923 19.. ROBERT R. KRAUL Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/2/23

17- I HEREBY CERTIFY, That I attended deceased from ....., 19.16.., to. 3/1 ....., 1923, that I last saw him alive on ..... 3/1 ....., 19.23 and that death occurred, on the date stated above, at 4-45 9 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(Duration) ....yrs. ....mos. 7 ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Edward Lebaub, M. D.

3/7, 1923 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park DATE OF BURIAL. April 4 1923

20-UNDERTAKER. John C. Mitchell ADDRESS 120 W Fayette St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

~~D74424~~ 16254.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74424

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 10 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Hawks.

(a) RESIDENCE No. 1200 Aisquith St. City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos., ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ or) ~~WIFE of~~: Nora Hoccraft (mother) 137 W. Fayette St.

6 DATE OF BIRTH (month, day, and year) Aug. 7, 1922.

7 AGE: Years — Months 7 — Days 26 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Edmond Hawks.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lewisburg Va.

12 MAIDEN NAME OF MOTHER: Nora Hoccraft.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. George

15 APR 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1923, to April 2, 1923, that I last saw h[illegible] alive on April 2, 1923, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (Not dysentery)

(duration) yrs. 1 mos + ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: J. H. Oliver Mem

DATE OF BURIAL: Apr 3 1923

20 UNDERTAKER: John O Mitchell

ADDRESS: 1201 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Isaac Sumerville

D74425 HEALTH DEPARTMENT—CITY OF BALTIMORE D74425

CERTIFICATE OF DEATH. 100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 902 Pierce st St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isac Sumerville

(Residence in Baltimore: No. 902 Pierce st St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed or Divorced, (Write the word.): Sngl

6-DATE OF BIRTH: May 19 (Month) (Day) 1913 (Year)

7-AGE: .....yrs. .....mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Non
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltcity

PARENTS.

10-NAME OF FATHER: Edw R Wright

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Edna Sumerville

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Wright

(Address) 902 Pierce

15-

Filed APR 3-1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 2 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or Inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) acute

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J H Greenbaum M. D. (Coroner.)

4-3, 1923 (Address) 117 W Saratoga st

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Edgewood	4-3 1923
20-UNDERTAKER,	ADDRESS
Dennis Easton	Balto

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74426

CERTIFICATE OF DEATH.

31

D74426

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 656 Mulberry ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Preston White

(Residence in Baltimore: No. 656 Mulberry St.; 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1896
(Month) (Day) (Year)

7-AGE, 33 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 186

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ella White

(Address) 656 Mulberry St

15- APR 3 — 1923 191.....

ROBERT R. KRAMER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1923, to March 31 1923, that I saw him alive on March 31 1923, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. M. Caudell M. D.

4/2, 1923 (Address) 2005 O'Sullivan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 4-3, 1923.

20-UNDERTAKER David Easley

ADDRESS 916 Eutaw

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74427

CERTIFICATE OF DEATH.

90 U.

REGISTERED No. D74427

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 S Potomac st ST., 1 WARD)

2-FULL NAME John W Elsate

(a) RESIDENCE No. 36 S Potomac st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie A Elsate

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Diesleman B & O R R

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer B & O R R 073

9 BIRTHPLACE (city or town) (State or country) Hartford Co Md

PARENTS

10 NAME OF FATHER Frederick Elsate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Annie Kenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Mamie A. Elsate
(Address) 36 S Potomac st

15 APR 3 - 1923 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1923, to 3/30, 1923, that I last saw h[illegible] alive on 3/30, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis P. Pedema

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) L D Traver M. D.

4/1, 1923 (Address) 2939 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutheran Cemetery Loppa Harford Co Md

DATE OF BURIAL Apr 4 1923

20 UNDERTAKER George J Smith

ADDRESS 1382 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. Information of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74428

CERTIFICATE OF DEATH. 19 159-002

Registered No. D74428

1-PLACE OF DEATH

City of BALTIMORE: (No. 1626 Hollins St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma Rahe

(Residence in Baltimore: No. 1626 Hollins St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	S

6-DATE OF BIRTH. April (Month) 1 (Day) 1923 (Year)

7-AGE. yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto City

PARENTS

10-NAME OF FATHER. Rosco Rahe

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Mary Hauer

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Rahe

(Address) 1626 Hollins

15-

Filed APR 3 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 2 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Foraman Injury by Crying

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) S Mas Gestation

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

April 3 1923 (Address) 700 E Eager

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cemetery

DATE OF BURIAL. Apr 3 1923

20-UNDERTAKER. Harry H. Witzke

ADDRESS 1521 W Lombard

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74429

CERTIFICATE OF DEATH.

6 129

D74429

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 Orleans St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Haywood Bolte Jr.

(Residence in Baltimore: No. 1743 Orleans St.; unknown yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Widowed

6-DATE OF BIRTH, July (Month) 4 (Day), 1862 (Year)

7-AGE, 60 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Stevedore

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... William Johnson Grandson

(Address)..... 1191 Bethel St.

15 APR 3 - 1923 Filed....., 191..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 22 1923, to March 31 1923, that I saw him alive on March 31 1923, and that death occurred, on the date stated above, at 9 10 p.m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(Duration) (est.) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency + Bronchitis

(Duration) yrs. 3 mos. ds.

(Signed) R T Johnson M. D.

4/2, 1923 (Address) 1429 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Ashley cemetery DATE OF BURIAL, April 4 1923

20-UNDERTAKER Milton Davis ADDRESS 315 N Eden St

U. S. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact definition of diseases important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74430 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D74430

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1147 N Front St ST., 5 WARD)

2-FULL NAME Ruby Freidman

(a) RESIDENCE NO. 1147 N Front St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Freidman

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Sol Freidman

11 BIRTHPLACE OF FATHER (city or town), (State or country) Russia

12 MAIDEN NAME OF MOTHER Fany Lenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Baltimore St

15 FILED APR 3 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to April 2, 1923, that I last saw him alive on April 2, 1923, and that death occurred, on the date stated above, at 5.9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tbc. Larynx—

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Tbc. Kidney (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. Exam-Gross

(Signed) Louis F Krumens, M. D.

, 19 (Address) 722 North Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4/3 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74431

CERTIFICATE OF DEATH.

4 74-001

D74431 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 W. Fayette St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Morris Fradenberg

(Residence in Baltimore: No. 721 W. Fayette St.; yrs. 48 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. ..... April (Month) 2 (Day) 1875 (Year)

7-AGE. 58 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Do Fradenberg

11-BIRTHPLACE OF FATHER, (State or Country) Russia

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto St

15- APR 3 - 1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 2 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. A few hours mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. P. Sem M. D. (Coroner.)

4-3 1923 (Address) 107 W Saratoga

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rock Rd. DATE OF BURIAL. 4-3 1923

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74432

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 5 Ward) 52

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Cirtrin

(Residence in Baltimore: No. 119 N. Exeter St.; 10 yrs., ... mos. ..... ds.)

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	white	single

6-DATE OF BIRTH, ... unknown ....., 1..... (Month) (Day) (Year)

7-AGE. 19 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... News dealer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Joseph Cirtrin

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Annie Katz

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltimore

15- Filed APR 3-1923 192..... ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April ~~MAY~~ 2/23, 192..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency

Mitral Stenosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Rheumatic Endocarditis (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Hollis M. D.

R~~MAY~~ 4/3/23 192.. (Coroner.) (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Int Earned	4-3 192 3
20-UNDERTAKER.	**ADDRESS**
Jack Lewis	1439 E Baltimore

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74433 D74433

CERTIFICATE OF DEATH.

Registered No. 161-00

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Morgan Colly

(a) Residence No. Terra Alta W. Va St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) —

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 4-3-23 2 days

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 9 hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Stewart Morgan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). W. Va.

12-MAIDEN NAME OF MOTHER, Marjorie Mauck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). W. Va.

11 (Informant) Forget Record

(Address)

13- Filed APR 3 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-3-23

17- I HEREBY CERTIFY, That I attended deceased from 4-3-23 2 days 1923, to 4-3-23 1923

that I last saw h.. alive on 4-3-23 1923

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: Premature birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) D. J. Brogan M. D.

, 19 (Address) Somerset & Fonda

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOV. Loudon Park Cem. — DATE OF BURIAL. 4/3/23

20-UNDERTAKER. Geo. A. Foley Sons — ADDRESS Fayette

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74434 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **D74434**

CERTIFICATE OF DEATH.

4 161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Morgan No 1

(a) Residence No. Terra Alta, W. Va. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 4-3-23 2.20 am

7-AGE. ..... yrs. 3 mos. ..... ds.

If LESS than 1 day, #7 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Stewart Morgan

11-BIRTHPLACE OF FATHER (city or town) W. Va. (State or Country),

12-MAIDEN NAME OF MOTHER, Marjorie Mauck

13-BIRTHPLACE OF MOTHER (city or town) W. Va. (State or Country),

11- (Informant) Mrs. Brenda

(Address).....

15- Filed APR 3 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-3-23

17- I HEREBY CERTIFY, That I attended deceased from 4-2-23 3 30 am, 19 23 to 4-3-23 9 am, 19 23

that I last saw h. alive on 4-3-23, 19 23

And that death occurred, on the date stated above, at 9 am, m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Both

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) D. J. Stevenson M. D.

, 19 (Address) Mercy Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Parents Lot Baltimore Md

DATE OF BURIAL, 4/3/23

20-UNDERTAKER. Geo A Farley

ADDRESS Fulton & Laythe

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D74435

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 N Streeper ST., 6 WARD)

2-FULL NAME Minnie Ennis

(a) RESIDENCE NO. 209 N Streeper ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno H. Ennis

6 DATE OF BIRTH (month, day, and year) Mar 19/1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work As Lonee

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Zurich Switzerland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Jno H. Ennis 209 N Streeper St

15 APR 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1923, to Apr 1, 1923, that I last saw h[illegible] alive on Mar 31, 1923, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Abdominal Metastases

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C H Mayer, M. D.

4/3, 1923 (Address) 5638 Belair

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 5-23 19

20 UNDERTAKER [illegible] — ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74436 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D74436

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2340 Barclay st. ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Russell.

(a) RESIDENCE. No. 2340 Barclay st. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mo. ... ds. How long in U. S., if of foreign birth? 20 yrs. ... mos. ... dt.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer H. Russell

6 DATE OF BIRTH (month, day, and year) Mar. 20 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0.37

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Ernest Chauvex

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Emily Lagarce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant (Address) Mr. Elmer H. Russell 2340 Barclay St.

15 Filed APR 3-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4. 1. 23. 19

17 I HEREBY CERTIFY, That I attended deceased from 10. 1. 21 19 ... to 4. 1. 23 19 ... that I last saw her alive on 4. 1. 23 19 ... and that death occurred, on the date stated above, at 2. 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

4/1/23 19 (Signed) J. Edward Norris, M. D.

(Address) 1430 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: 4/4 1923

20 UNDERTAKER: J. Fred McCully

ADDRESS: 130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74437 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

48 D74437

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 363 Element Ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Watson

(Residence in Baltimore: No. 363 Element Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
male	colored	Married

6-DATE OF BIRTH. ..Unknown....., 1.....
(Month) (Day) (Year)

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chemical Worker
(b) General nature of industry, business, or establishment in which employed (or employer): Tyson 86

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Frank Watson

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Elizabeth Phillips

13-BIRTHPLACE OF MOTHER, (State or Country) Calvert Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Wilson

(Address) 363 Element St

15 Filed APR 3 - 1923 192

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 2, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma ?
Non Tantrum ? ?
Hypernephroma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Septic Intoxication (Duration) yrs. 6 mos. ds.

(Signed) James M Faulon M. D.
(Coroner.)

April 2 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
National Cem.	April 4 1923
20-UNDERTAKER. E. W. Dill	ADDRESS 3109 Fredk. Ave;

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74438

CERTIFICATE OF DEATH.

164

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5330 Belmore Ave ST., 27 WARD)

2-FULL NAME Mrs Margaret E. Gardiner

(a) RESIDENCE NO. 5330 Belmore Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ——— mos. ——— dys. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jabez Gardiner

6 DATE OF BIRTH (month, day, and year) April 22 37x

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lewis Hoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Silas F. Gardiner
(Address) 5330 Belmore Md

15 Filed ....., 19.....

ROBERT P. HARTIGAN,
Burial Permit Clerk. Registrar

R 3 — 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1923

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1923, to April 3, 1923,

that I last saw h— alive on April 2, 1923,

and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Senility

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) E. R. Emmons, M. D.

4-3, 1923 (Address) 5016 Park Hts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sandymount Cemetery

DATE OF BURIAL April 5 1923

20 UNDERTAKER W. M. Rockow

ADDRESS 2238 W Balto

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b
of certificates.

Spec—1-1021—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74439

CERTIFICATE OF DEATH.

100-001 D74439

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., N WARD)

2-FULL NAME George Davidson

(a) RESIDENCE NO. ? ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed APR 3-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1923, to March 30, 1923, that I last saw him alive on March 30, 1923, and that death occurred, on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

3/31/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS

Per. Wm. E. WOODALL,

APR 3-1923

mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

UNIVERSITY OF MARYLAND.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74440

D74440

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Myrtle ave ST. WARD)

2-FULL NAME Patrick H. McNally

(a) RESIDENCE NO. 1009 Myrtle ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Sarah J. Rogers

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years 71 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Subway dept.

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Patrick McNally

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kate Sprowl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sarah McNally

(Address) 1009 Myrtle ave

15 Filed Robert F. Harrison, Registrar

APR 3-1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1923 to April 1, 1923.

that I last saw him alive on April 1, 1923,

and that death occurred, on the date stated above, at 1 Am m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Hoerle, M. D.

April 2, 1923 (Address) 1584 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 4/4 1923

20 UNDERTAKER J. F. Fahey & Son — ADDRESS 1358 Eight Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Particulars of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74441

CERTIFICATE OF DEATH.

38

D74441

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1041 S. Howard ST. 23 WARD)

2-FULL NAME Baby Boy Overton

(a) RESIDENCE. NO. 1041 S. Howard ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2 Hrs 15 minutes	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Willie Jackson

11 BIRTHPLACE OF FATHER (city or town) Cambridge
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lena Mullen

13 BIRTHPLACE OF MOTHER (city or town) Elizabeth City
(State or country) North Carolina

14 Informant
(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1923

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to March 31, 1923, that I last saw h.[illegible] alive on March 31, 1923, and that death occurred, on the date stated above, at 4 00 A m.

The CAUSE OF DEATH* was as follows:

Prematurity
(3 2 mths)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann Reaction

(Signed) Thornwood Wilson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health

ADDRESS

APR 3 - 1923

APR 3-1923 Robert P. Harrison,
Burial Permit Clerk.

Per. Wm. H. WOODALL

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

D74442 HEALTH DEPARTMENT—CITY OF BALTIMORE D74442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Front St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

(Residence in Baltimore: No. ..... St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Col'd	Married

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE. about 52 If LESS than 1 day, ... yrs. ..... mos. ..... ds. ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison

FILED APR 3-1923 192.. Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, found Mch 27. 23
..... 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... Inquest ..... (Inquest, autopsy or Inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned
accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

..... 192.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
PUBLIC CEMETERY	..... 19...
20-UNDERTAKER. (Commissioner Health, Per Wm. E. Woods)	ADDRESS APR 3 - 1923

THE MORGUE.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74443 HEALTH DEPARTMENT—CITY OF BALTIMORE D74443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE (No. Foot of Clinton St. 26 Ward) 182

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced, (Write the word): Unknown

6-DATE OF BIRTH: Unknown (Month) (Day) 1... (Year)

7-AGE: About 35 yrs. mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Unknown (b) General nature of industry, business, or establishment in which employed (or employer): 08

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- Robert P. Harrison, Registrar.

APR 3 1923 192...

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner.)

193... (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY

DATE OF BURIAL, APR 3 - 1923 19...

20-UNDERTAKER, Commissioner Health, ADDRESS

Per. Wm. E. Woodside

If state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74444 ✓ D74444

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74444

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Pennington Ave ST., 13 WARD)

2-FULL NAME Abbie M. Gardner

(a) RESIDENCE NO. 910 Pennington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 70 yrs. 9 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John H. Gardner

6 DATE OF BIRTH (month, day, and year) June 22-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Providence
(State or country) Rhode Island

PARENTS

10 NAME OF FATHER ~~Barney~~ George Grant

11 BIRTHPLACE OF FATHER (city or town) Providence
(State or country) Rhode Island

12 MAIDEN NAME OF MOTHER Priscilla Pearce

13 BIRTHPLACE OF MOTHER (city or town) Providence
(State or country) Rhode Island

14 Informant Mrs. Nella La Porte
(Address) ~~910 Pennington Ave~~ ~~Robert E. Harrison~~

15 APR 3-1923 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Apr 3, 1923, that I last saw her alive on Apr 2, 1923, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Uremia or Kidney Disease

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos A Schaefer, M. D.

Apr 3, 1923 (Address) 1103 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Providence, Rhode Island	April 4 1923
20 UNDERTAKER	ADDRESS
H. Allen Fuller	2902 Garrison Blvd

Information should be carefully supplied. AGE should be stated EXACTLY. PHRASING should be such that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74445

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST., 13 WARD)

2-FULL NAME Sarah Rosenthal

(a) RESIDENCE NO. 2117 Brookfield Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abel Rosenthal

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Intkam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Intkam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis (Address) 1439 E Balto St

15 Filed 3-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1923, to March 30, 1923, that I last saw h[illegible] alive on March 30, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Isidor Jury M. D.

3/30, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rock Road

DATE OF BURIAL 4/3 1923

20 UNDERTAKER Jack Levis 1439 E Balto St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74446

CERTIFICATE OF DEATH.

129 D74446

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 W. Saratoga ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rommel

(a) RESIDENCE NO. 1907 W. Saratoga ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1850

7 AGE: Years 72 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Ernest Rommel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliza Calmay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank Rommel
(Address) 1907 W. Saratoga St

15 Robert P. Harrison, Burial Permit Clerk. Registrar

R 3 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1923, to April 3 1923, that I last saw h[er] alive on March 31, 1923, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mns. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles T. Beck M. D.

April 3 1923 (Address) 20 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: 4/4 1923

UNDERTAKER: Chas. P. Graves & Son

ADDRESS: 1180 W. Royal Ave

information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, HOURS or MINUTES must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74447

CERTIFICATE OF DEATH.

129

D74447

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Holbrook ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jonathan German

(Residence in Baltimore: No. 1708 Holbrook St.; 70 yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Widower

6-DATE OF BIRTH, October 17, 1853 (Month) (Day) (Year)

7-AGE, 70 yrs. 5 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Stanbury German

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Louise Norwood Smithers

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Irving German

(Address)..... 1808 Fremont Av

15-

Filed 4-3-1923 Robert P. Harrison, M.D. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3rd, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1923, to April 3rd 1923, that I saw h[im] alive on 6 1/2 P.m. April 3 1923, and that death occurred, on the date stated above, at 1 55 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Acute Peritonitis

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(Duration) yrs. mos. ds.

(Signed) Joseph D. Llewellyn M. D.

April 3, 1923 (Address) 719 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, April 6th, 1923

UNDERTAKER Chas. R. Crowston

ADDRESS 1140 W. Royal Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Geo. A. Baker ✓

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74448 D74448

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4603 James (Lanvale) ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A Baker

(a) RESIDENCE NO. 4603 James ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie A. Baker

6 DATE OF BIRTH (month, day, and year) 2/1/1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Express Hauling

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant Mrs Geo A Baker. (Address) 4603 James ave

15 Robert P. Harris Registrar

R 3—1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to April 1, 1923, that I last saw h alive on April 1, 1923, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency. Cardiac (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Swain, M. D.

4/1, 1923 (Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	4/4/23
20 UNDERTAKER	ADDRESS
George J. Pulk	1735 Harford ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74449

CERTIFICATE OF DEATH. 100-001

D74449

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3318 Foster Ave ST., 76 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anfang

(a) RESIDENCE NO. 3318 Foster Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Anfang.

6 DATE OF BIRTH (month, day, and year) Dec. 10-1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	82	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Germany.

PARENTS

10 NAME OF FATHER John Barnickel

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant (Address) Mrs. Mary Zebhein 3318 Foster Ave

15 Filed Robert P. Harrison Registrar

R 3-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 2, 1923, that I last saw her alive on April 2, 1923, and that death occurred, on the date stated above, at 5.00 6. m.

The CAUSE OF DEATH* was as follows:

Pneumonia-(Broncho)

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Geo Lockwood Jr, M. D.

, 19 (Address) 806 S. 3. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL April 6 1923

20 UNDERTAKER Lielz and Zeiler. ADDRESS 403 S. Wolfe St

AGE should be stated EXACTLY. PHYSICIANS are requested to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that

Spec.—1-10-21—M&T—1500 Bks.

D74450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74450

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 777 N. Ellwood Ave. ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Crawford.

(a) RESIDENCE NO. 777 N. Ellwood Ave ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Crawford.

6 DATE OF BIRTH (month, day, and year) Aug 15-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) E. Dist. 661

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Crawford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Elizabeth Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Elizabeth Crawford.

(Address) 777 N. Ellwood Ave

15 Filed ..., 19 ..... Registrar

Robert P. Harrison,

PR 3-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept - , 1922, to March 31 - , 1923, that I last saw h — alive on March 31, 1923, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dis - Valvular -

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) M. P. C. Brewer, M. D.

, 19 (Address) 125 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL April 4 1923

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-23—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74451

D74451

CERTIFICATE OF DEATH. 109-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4100 E. Lombard. ST., 76 WARD)

2-FULL NAME Dolores A. Echenning.

(a) RESIDENCE NO. 4100 E. Lombard St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2-1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Echenning.

11 BIRTHPLACE OF FATHER (city or town) N. J.
(State or country)

12 MAIDEN NAME OF MOTHER Regina Bohmann.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant John Echenning.
(Address) 4100 E Lombard St.

15 3-1923 . 19 Robert F. Garrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to April 7, 1923,

that I last saw h Ev alive on April 2, 1923,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Ludwig's Angina

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of April 2/23

Was there an autopsy? No Physical Examination

What test confirmed diagnosis? Physical Examination

(Signed) Isaac M. Brooks, M. D.

19 (Address) 235 E Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL April 4 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74452

CERTIFICATE OF DEATH.

93 D74[illegible]

REGISTERED NO. D74452

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Visitation Convent ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Leonard Spellman.

(a) RESIDENCE NO. Visitation Convent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer): 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C

PARENTS

10 NAME OF FATHER: John F. Spellman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C

12 MAIDEN NAME OF MOTHER: Catherine Spellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C

14 Informant: Sister M. Aloysius Doonan

(Address) Visitation Convent.

15 Filed APR 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1923, to April 2, 1923, that I last saw h-e alive on April 1, 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Acute attack of heart - probably thrombus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Inflammation of veins in leg

(duration) about 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Heart attack - Arterio sclerosis

(Signed) Chas O'Donovan, M. D.

April 4, 1923 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 4th 1923
20 UNDERTAKER: Henry J. Hartwell	ADDRESS 2236 W. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001 D74453

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1045 Ridgely St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

2-FULL NAME John Ottman.

(Residence in Baltimore: No. 1045 Ridgely St. St.; yrs. 68 mos. 5 ds. 17)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Widower.

6-DATE OF BIRTH, October 15th. 1854, 1..... (Month) (Day) (Year)

7-AGE. 68 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Ottman.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth.----

13-BIRTHPLACE OF MOTHER, (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Jones.

(Address) 4005 Leading Ave, Cleaveland Ohio.

15- Filed APR 4 - 1923. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 1st. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquire (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquire (Inquest, autopsy or Inquiry.) find that said deceased came to h.s. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Illuminating gas
Asphyxia.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Oct 3 1923 (Address) 10 W. S. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Fifth German Luth. Cem	4 - 4th 1923

20-UNDERTAKER.	ADDRESS
James Digiacomo & Son	1000 S Face St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Sample.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74454

CERTIFICATE OF DEATH.

74-001 D74454

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 701 Scott ST., 21 WARD)

2-FULL NAME Margaret Kammer

(a) RESIDENCE NO. 701 Scott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of mour

6 DATE OF BIRTH (month, day, and year) April 6-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or estsblishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert Kammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Saurwein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Robert Kammer (Address) 701 Scott

15 Filed APR 4 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1923, to April 2, 1923, that I last saw h alive on April 2 1923, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edw Greenbaum, M. D.

(Address) 517 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 4-5 1923

20 UNDERTAKER James D'Ignan & Son

ADDRESS 1000 S Paca St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74455

D74455

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 866 Columbia Ave St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... E. E. Hopkins

(a) Residence No. 866 Columbia Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Hopkins

6-DATE OF BIRTH (month, day and year) Feb 22 1829

7-AGE. 93 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER John E. Hopkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Mrs Elizeda Isabel

(Address) 2027 Eutaw St

15- APR 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

Hosp. 727 Columbia Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 2 23

17- I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1922 to April 2, 1923.

that I last saw h... alive on April 2, 1923

and that death occurred, on the date stated above, at 5 10 m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? In

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris Stoag M. D.

4/3, 1923 (Address) 729 Park Ave

(*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. - (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem Md

DATE OF BURIAL. Sept 5 1923

20-UNDERTAKER. William Cook & Sons

ADDRESS Baltimore

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Write in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74456

REGISTERED NO. 70 D74456

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Cathedral ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna. Estella. Parker

(a) RESIDENCE NO. 1126 Cathedral ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Hugh. Frazier. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER M. Genevieve Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant M. Hugh. F. Parker
(Address) 1126 Cathedral St

15 APR 4-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to April 3, 1923, that I last saw her alive on April 3, 1923, and that death occurred, on the date stated above, at 10.55 A.m.

The CAUSE OF DEATH* was as follows:

Acute encephalitis -

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry D. McCarty, M. D.

4-3, 1923 (Address) 837 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery.	Apr. 5 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons	1301 E Eager St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 blks. 74457 Owson Adesman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74457 D74457

CERTIFICATE OF DEATH

129 D74457

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owsey Adesman

(a) RESIDENCE NO. 1538 Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1874.

7 AGE 48 Years 3 Months 22 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Adesman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sital Kopia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 Eutaw St

15 FILED APR 4-1923 ROBERT B. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1923, to April 3, 1923, that I last saw him alive on April 3, 1923, and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory.

(Signed) Edwin B. Jarrett, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodedale — DATE OF BURIAL 4/4 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Eutaw St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D74458

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D74458

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Mount ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Edward Turnstall

(Residence in Baltimore: No. 405 N. Mount St.; 1 yrs., 2 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Child

6-DATE OF BIRTH, Jan (Month) 18 (Day), 1922 (Year)

7-AGE, 1 yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, George H. Turnstall

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Helen E Turnstall

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo E. Shannon

(Address) 700 Fulton Ave

15- APR 4 - 1923 Filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 1 1923, to Apr 2 1923; that I saw h in alive on April 2 1923, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho = Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ....yrs. ✓ mos. 2 ds.

(Signed) George E Shannon M. D.

Apr 2, 1923 (Address) 700 Fulton ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mont Auburn	Apl 4, 1923
20-UNDERTAKER John F Emery	ADDRESS 538 Dolphin St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74459

CERTIFICATE OF DEATH.

44 D74459

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 George ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Jackson

(a) RESIDENCE NO. 733 George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Jackson

6 DATE OF BIRTH (month, day, and year) March 10th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	50 ~~49~~	~~11~~	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Loading Ships

(c) Name of employer Turnbull Shipping Co

9 BIRTHPLACE (city or town) (State or country) Essex Co Virginia

PARENTS

10 NAME OF FATHER Henry Jackson

11 BIRTHPLACE OF FATHER (city or town) Essex Co (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) Essex Co (State or country) Va

14 Informant William J Jackson (Address) 725 S Longwood St

15 DATE RECD APR 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/23 19

17 I HEREBY CERTIFY, That I attended deceased from apl 1st, 1923, to apl 3rd, 1923, that I last saw him alive on apl 3, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Palpable Liver Nodes

(Signed) Gustav Rohlman M. D.

, 19 (Address) 65 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mont Auburn

DATE OF BURIAL Apl 4 1923

20 UNDERTAKER John H. Owens

ADDRESS 538 Dolphin St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74460

CERTIFICATE OF DEATH.

38 ✓ D74460

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Paul Scherman

(a) RESIDENCE NO. ? ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 FILED APR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 22, 1923 to April 2, 1923,
that I last saw him alive on April 2, 1923,
and that death occurred, on the date stated above, at 3:00 P.M.
The CAUSE OF DEATH* was as follows:

Tabo-paresis
(Syphilitic)

(duration) 1 yrs. mos ½ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. A. McKay, M. D.

4-3-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
I A German	April 4 1923
20 UNDERTAKER	ADDRESS
Peter Nicolaus 2060	Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74461

CERTIFICATE OF DEATH.

129 D74461

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 S. Arlington ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel B. Dorsey

(a) RESIDENCE NO. 124 S. Arlington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara R. Dorsey

6 DATE OF BIRTH (month, day, and year) 10/7/45

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jno. Morgan

(Address) 124 S. Arlington Ave

15 APR 4 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/23 19

17 I HEREBY CERTIFY, That I attended deceased from 7/6/22, 19, to 4/3/23, 19, that I last saw h— alive on 4/3/23, 19, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Chr Diffg Nephritis

" Hypertrophy

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edward J. Long, M. D.

4/4/1923 (Address) 124 S. Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National — DATE OF BURIAL April 5 1923

20 UNDERTAKER J. J. Field — ADDRESS 1200 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D74462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 William St. ST., 24 WARD)

2-FULL NAME Leonard Broadwater

(a) RESIDENCE NO. 813 William St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Dec. 2 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mariner

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Accomac Co. Va.

PARENTS

10 NAME OF FATHER: Walter Broadwater

11 BIRTHPLACE OF FATHER (city or town) (State or country): Accomac Co. Va.

12 MAIDEN NAME OF MOTHER: Mary Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Accomac Co. Va.

14 Informant: Mrs. Spencer D. Hall

(Address): 813 William St.

15 Filed APR 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March 9/23, 19.., to April 3rd, 19.23.

that I last saw him alive on April 3, 19.23.

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): No other Contributing cause

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B. Hall, M. D.

(Address) 1703 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pocomoke City via Crisfield B&A RR

DATE OF BURIAL: April 4 1923

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light

N. B. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D74463

CERTIFICATE OF DEATH

32

Registered No. D74463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 Gough St.; Ward) N

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sheldon A Hurd

(Residence in Baltimore: No. 3508 Gough St Balto Md St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	M

6-DATE OF BIRTH: July (Month) 10 (Day), 1898 (Year)

7-AGE: 24 yrs. 10 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Clerk 109

9-BIRTHPLACE (State or country): Balto Co Md

PARENTS

10-NAME OF FATHER: Hurd

11-BIRTHPLACE OF FATHER (State or country): England

12-MAIDEN NAME OF MOTHER: Mary E Brownbridge

13-BIRTHPLACE OF MOTHER (State or country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gwladys Hurd

(Address) 2 E Lafayette Ave

15-

APR 4—1923 ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 17, 1923, to April 2 1923, that I saw him alive on April 2 1923, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Tuberculer Meningitis

(Duration) X yrs 2 mos 16 ds.

Contributory (SECONDARY) Lobar Pneumonia

(Duration) X yrs X mos 2 ds.

(Signed) Jas L Phillips M. D.

April 3 1923 (Address) 2478 Eutaw

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: April 5, 1923

20-UNDERTAKER: John Merrick

ADDRESS: 2008 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

162509
D74464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74464

CERTIFICATE OF DEATH.

X155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bulley

(a) RESIDENCE NO. 230 E. 46th St. Savannah, Georgia

(Usual place of abode) ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~or WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1920.

7 AGE: Years 2 Months 4 Days 29

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Charles K. Bulley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Rebecca Ingraham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 Filed APR 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1923, to April 3, 1923, that I last saw her alive on April 3, 1923, and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Mastoiditis

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Septicaemia + Meningitis

(duration) yrs. mos. 5+ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Phila Pa — DATE OF BURIAL: Apr 4 1923

UNDERTAKER: John J Mitchell — ADDRESS: 1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D74465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 11-001 D74465

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Retreat ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Elizabeth Hunter

(a) RESIDENCE NO. 1603 Retreat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 8th, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Alfred A. Hunter

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Frances E. Snyder

13 BIRTHPLACE OF MOTHER (city or town) Howard Co
(State or country) Md.

14 Informant Alfred A. Hunter
(Address) 1603 Retreat St

15 Filed APR 4 - 1923 19 ROBERT R. KRAUFER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd, 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1923, to Apr 3, 1923, that I last saw her alive on Apr 3, 1923, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer C. Todd M. D.

4/4, 1923 (Address) 735 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL April 15th. 23

20 UNDERTAKER Richard Gore

ADDRESS 728 N. Eutaw

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74466

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D74466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Montpelier ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Graham

(a) RESIDENCE NO. 1700 Montpelier ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Gertrude M.

6 DATE OF BIRTH (month, day, and year) Jan 2, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief clerk Traffic Dept.

(b) General nature of Industry, business, or establishment in which employed (or employer) B. & O.

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Jackson Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Margaret McConnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Gertrude M. Graham

(Address) 1700 Montpelier

15 APR 4-1923 ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1921, to March 29, 1923, that I last saw h[illegible] alive on March 23, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Multiple Arthritis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fritz J Kreuzer, M. D.

April, 19 23 (Address) 2900 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Braddock, Pa.

DATE OF BURIAL April 7 1923

20 UNDERTAKER Herbert Parker

ADDRESS 1734 Eager

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Hopkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74467

CERTIFICATE OF DEATH.

90 D74467

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 ~ Hargrove al ST., 11 WARD)

2-FULL NAME Elizabeth Weaver Hop Tu

(a) RESIDENCE NO. 505 ~ Hargrove al ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: fem

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Hop Tu

6 DATE OF BIRTH (month, day, and year): June 8, 1869

7 AGE: Years 53; Months 9; Days 24; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store Woman

(b) General nature of industry, business, or establishment in which employed (or employer): China dept Store

(c) Name of employer: Joel Bettinger & Bro

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: ? Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore md

12 MAIDEN NAME OF MOTHER: Mary Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore md

14 Informant: Mary Taylor (Wife)

(Address) 504 ~ Hargrove ad

15 APR 4 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to April 2, 1923, that I last saw h alive on April 2, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary): Mitral Insf.

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) C. E. Jackson, M. D.

4/4, 1923 (Address) 1618 W. Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 4/5 1923

20 UNDERTAKER: Samuel Wemley

ADDRESS 1178 N Eutaw St

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Harman

D74468 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74468

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2105 Druid Hill ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Benj. Harman

(a) Residence No.....2105 Druid Hill a St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Negro

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harman

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Waiter

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Snowhill (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Peter Harman

11-BIRTHPLACE OF FATHER (city or town) Snowhill (State or Country), Md

12-MAIDEN NAME OF MOTHER, Catherine Johnson

13-BIRTHPLACE OF MOTHER (city or town) Snowhill (State or Country), Md.

(Informant) Edward Harman

(Address) 2105 Druid Hill ave

15-Filed APR 4 - 1923

16- ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1923, to April 2, 1923, that I last saw him alive on April 2, 1923, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Heart dilatation

Uraemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. 2 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John D. King, M. D.

April 3 1923 (Address) 1425 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet — DATE OF BURIAL, 4/5, 1923

20-UNDERTAKER, Jane C. Hennessey — ADDRESS Mt Wilson Md

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.P.S.—400 Blks.

D74469 HEALTH DEPARTMENT—CITY OF BALTIMORE 47 D74469

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Wright

(a) Residence No. 537 Hatherd Alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) 1859

7-AGE.	If LESS than 1 day.
63 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Alfred Wright

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md. ?

12-MAIDEN NAME OF MOTHER Louise Tindle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md. ?

14-(Informant) Municipal Hospital Records

(Address)

15-Filed APR 4 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 31, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 7, 1923 to March 31, 1923.

that I last saw her alive on March 30, 1923.

and that death occurred, on the date stated above, at 7:40 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

3-31 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 4/5 1923
W. Laurel Cem	
20-UNDERTAKER, James T. Hendley	ADDRESS 578 Eddy St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Francis E. Jackson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74470

CERTIFICATE OF DEATH.

31 D74470

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Eutaw & Center sts or Mt Winans ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis E. Jackson

(Residence in Baltimore: No. Eutaw & Center sts Mt Winans St.; 38 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	Colrd	Married

6-DATE OF BIRTH, June 1, 1884 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
38 yrs. 10 mos. 2 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unfortunate Jackson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada Jackson

(Address) Mt Winans Eutaw st

15-

Filed APR 4 - 1923 1921 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 3 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1922, to 4-2 1923, that I saw h[im] alive on 4-2- 1923, and that death occurred, on the date stated above, at 4.25 a m.

The CAUSE OF DEATH* was as follows:

chronic tuberculosis of Lungs.

Pulmonary disease.

Intercadosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W B Hall M. D.

4-3-, 1923 (Address) Halethorp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Lubyan Cemtery	April 6, 1923
20-UNDERTAKER	ADDRESS
Wm Gerk Hooper	406 W. Conway St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 MAT 1500 Blks.

D74471

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74471

CERTIFICATE OF DEATH.

X129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arron Mondle

(a) RESIDENCE NO. Harmans, Md. ST., WARD Baltimore Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Mondle

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. of min.
	55?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Mondle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lucy Mondale (Address) Harmans via Md

15 APR 4 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1923, to April 2, 1923, that I last saw him alive on April 2, 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Anemia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Wm. J. Sutton, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mark Church Cem Harmans Md

DATE OF BURIAL 2nd April 1923

20 UNDERTAKER Wm Gerhardt

ADDRESS W. Conway St

N. B.—WRITE PLAINLY WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74472

CERTIFICATE OF DEATH.

100-001 D74472

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Emily Carpentier

(a) Residence No. 17 N. Broadway St., Ward... Mass.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 11, 1892

7-AGE. 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Canada

PARENTS.

10-NAME OF FATHER, Francis Carpentier

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Canada

12-MAIDEN NAME OF MOTHER, Barbeau

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Canada

14- (Informant)... Claude Magotte

(Address)... Millbury Mass

15- Filed APR 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3/1923

17- I HEREBY CERTIFY, That I attended deceased from Mar 26, 1923, to April 3, 1923, that I last saw h.. alive on April 3, 1923, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Respiratory Failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted, if not at place of death? 17 N. Broadway St.

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) David J. Perazzo M. D.

4/4/23 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Millbury Mass

DATE OF BURIAL, April 6 1923

20-UNDERTAKER. Geo. J. Smith

ADDRESS 1532 Eutaw St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D74473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 E Eat. Preston and Eldemont Sts., 12 WARD)

2-FULL NAME Mary A Payne

(a) RESIDENCE No. Preston and Ellamont Sts., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John J Payne

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Catherine J. Denver

13 BIRTHPLACE OF MOTHER (city or town) Boston
(State or country) Mass

14 Informant Mrs A J Messinger
(Address) Preston and Ellamont Sts

15 APR 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1923, to April 3 1923, that I last saw h alive on April 2 1923, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. O'Neill, M.D.

4/3, 1923 (Address) 108 N Bethel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 4-5- 1923

20 UNDERTAKER H. C. Brauning Son

ADDRESS 517 N. Schroeder St

N. B.—WRITE PLAINLY, WITH INK AND IN PRINCIPAL RESIDENCE. PAGE ... of ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74474

CERTIFICATE OF DEATH.

49

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Proctor ST., 10 WARD)

2-FULL NAME Bernard Mulhall

(a) RESIDENCE No. 1119 Proctor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 42 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margt. Mulhall

6 DATE OF BIRTH (month, day and year) March 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Mulhall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margt. Mulhall
(Address) 1119 Proctor St

15 APR 4—1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1922, to April 3, 1923.

that I last saw him alive on April 3, 1923.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostat

(duration) yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Endocarditis & Cystitis (duration) 1 yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? 1119 Proctor St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Fenton, M. D.

4/3/23 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 6 1923
20 UNDERTAKER	ADDRESS
K.C. Wiedefeld	914 Greenmount Av

THIS BLANK, WHEN ONCE RECEIVED, SHOULD BE FILLED OUT WITHOUT DELAY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74475

CERTIFICATE OF DEATH.

73

D74475

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 E Biddle ST. 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Murphy

(Residence in Baltimore: No. 603 E. Biddle St.; 59 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Sept 4 (Month) ..... (Day), 1841 (Year)

7-AGE, 81 yrs. 6 mos. 28 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)..... D.

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thos. Murphy

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Murphy

(Address) 603 E. Biddle St.

15-

Filed ..... Robert R. Harrison, ... Registrar.

4 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1 1923, to April 2 1923, that I saw him alive on April 1 1923, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans &
Arteria Sclerosis (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mary F. Vaughan M. D.

April 3, 1923 (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, April 5, 1923

20-UNDERTAKER H. C. Wiedefeld & Co — ADDRESS Fremont Ave

P.S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-23—M&T—1500 Bks.

D74476 HEALTH DEPARTMENT—CITY OF BALTIMORE D74476

CERTIFICATE OF DEATH. 129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lunt Falls Gen Hosp St. 21 WARD)

2-FULL NAME Mrs Theresa M Boswell

(a) RESIDENCE NO. 1237 Cleveland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. W. Boswell

6 DATE OF BIRTH (month, day, and year): Sept 19-1866

7 AGE: Years 57 Months 6 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Bernard Saddman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa Meinke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo. W. Boswell
(Address) 1237 Cleveland Ave.

15 APR 4-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1923, to April 4, 1923, that I last saw h[illegible] alive on April 4, 1923, and that death occurred, on the date stated above, at 6 1/2 A.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Cardio Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Cameron, M. D.

(Address) Lunt Falls Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem DATE OF BURIAL: Apr 6 1923

20 UNDERTAKER: Wm J Gickner & Sons ADDRESS: N Y Pa

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74477 ✓ 89 D74477

CERTIFICATE OF DEATH.

D74477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3623 Reisterstown St. R15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Musgrave

(a) RESIDENCE NO. 3623 Reisterstown ST. Rd WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Musgrave

6 DATE OF BIRTH (month, day, and year) Sept. 21, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Designer

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Musgrave

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Margaret A. Musgrave

(Address) 3623 Reisterstown Rd

15 Filed ..... Robert P. Harrison, Registrar

4-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 31, 1923, to Apr 2, 1923, that I last saw him alive on Apr 2, 1923, and that death occurred, on the date stated above, at 1.20 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Angina Pectoris - Myocard-itis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Emil P. Mather M. D.

, 19 (Address) #1711 N. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Apr 5, 1923
20 UNDERTAKER	**ADDRESS**
Wm J Ricker & Sons	North Av.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D74478 HEALTH DEPARTMENT—CITY OF BALTIMORE D74478

CERTIFICATE OF DEATH. 100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Horningstar

(a) Residence No. 1222 Riverside Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1872

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Richard Horningstar

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Sarah Galloway

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 31, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 31, 1923 to March 31, 1923 that I last saw h. in. alive on March 31, 1923 and that death occurred, on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Mecray M. D.

4-2-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL, 1923

20-UNDERTAKER. Commissioner Health. ADDRESS

Dep. Wm. E. WOODALL.

APR 4-1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PR 4-1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74479

D74479

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hardie Ford

(a) RESIDENCE NO. 116 N. Biddle st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Hardie Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) ~~Robert P. Harrison~~ UNIVERSITY OF MARYLAND.

15 APR 4-1923 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1923, to March 30, 1923, that I last saw him alive on March 30, 1923, and that death occurred, on the date stated above, at 11.20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dadabacca M. D.

3-31-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER Commissioner Health, Wm. R. Woodward

DATE OF BURIAL 19

ADDRESS APR 4-1923

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74480

D74480

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 Edmondson Av. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo H Beall

(a) RESIDENCE. No. 1920 Edmondson Av. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~the wife of~~ Anna Mae Beall

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

008

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER Geo H Beall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Anna Mae Beall

(Address) 1920 Edmondson Ave

15 APR 4 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1923, to Apr 3, 1923, that I last saw him alive on Apr 3 1923 and that death occurred, on the date stated above, at 6 10 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer C. Todd, M. D.

4/4, 1923 (Address) 735 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine DATE OF BURIAL APR 6 1923

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE.

WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. SECTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74481

D74481

CERTIFICATE OF DEATH.

99-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Belvedere Ave ST., 27 WARD)

2-FULL NAME Emerson Fields

(a) RESIDENCE NO. 21 Belvedere Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6. 8. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Allen Fields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Winifred Cottingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Allen Fields (Address) 21 Belvedere Ave

15 APR 4—1923 Robert J. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3. 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25, 1923, to Apr. 3, 1923, that I last saw him alive on Apr. 3, 1923, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Stridulous Laryngitis. following acute Bronchitis.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Beelen, M. D.

4. 3. 1923 (Address) 618 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Woodlawn	Apr 5 1923
20 UNDERTAKER	ADDRESS
Horace H. Burgee	363 Pratt St.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74482

CERTIFICATE OF DEATH.

185

D74482

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Edgewood Sanatorium ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie J. Duncan

(Residence in Baltimore: No. 722 Caton Ave. St.; 50 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, April 13th (Month) (Day), 1836 (Year)

7-AGE, 86 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Robert Brown

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Duncan

(Address) 722 Caton Ave.

15- APR 4 - 1923

Robert J. Harrison, 191.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 3 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 10 1923, to April 3 1923, that I saw her alive on April 2 1923, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

General Debility superinduced by Fractured Hip and old age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. 23 ds.

(Signed) E. H. Duncan M. D.

Apr. 3, 1923 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 23 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 722 Caton Ave

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, 4/5, 1923

20-UNDERTAKER E. J. Fanning & Son-1938 E. Lafayette Ave.

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74483 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74483

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Battery ST.: 24 WARD)

2-FULL NAME Bertha G. Franklin

(a) RESIDENCE. NO. 1509 Battery Ave. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. H. Franklin

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phila. Pa.
(State or country)

PARENTS

10 NAME OF FATHER Harry E. Hampton

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Pellum

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Wm. H. Franklin
(Address) 1509 Battery ave.

15 Filed Robert P. Harrison, Registrar

APR 4-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3d 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-5 1922, to 4-3 1923, that I last saw h.. alive on 4-3 1923 and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac decompensation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis with Hypertension (duration) 1 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Brown M. D.

, 19 (Address) 1319 Eight St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	3/6/ 1923

20 UNDERTAKER ADDRESS

C. J. Fanning & Son - 1460 Battery Ave.

BE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back

Spec—12-23-21—E.B.R.S.—400 Bks.

D74484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74484

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 4337 Ready Ave Ward 27)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen M. Talbert

(a) Residence No. 4332 Ready Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 1858

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None. [illegible]

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Robert Talbert

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) [illegible]

14-

(Informant) Mary C. McLaughlin

(Address) 4337 Ready Ave

15-

FILED APR 5 – 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3 1923

17- I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to April 3, 1923, that I last saw h.e alive on March 3, 1923, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Senility

Softening of Brain

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John J. Deaver, M. D.

, 19 (Address) 101 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Cem

DATE OF BURIAL, April 5, 1923

20-UNDERTAKER John D. Mitchell

ADDRESS 1201 W. Fayette St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74485

D74485

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Brown

(a) RESIDENCE NO. 1119 Kirk st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celestine Brown

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: John F. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Medley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address) M.T.H.

15 APR 5 - 1923 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to April 3, 1923, that I last saw him alive on April 3, 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B. T. in sputum, X-ray

(Signed) Clarence L. Dalaplaine, M. D.

4-3-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: APR 6 1923

20 UNDERTAKER: Samuel T. Hemsley — ADDRESS: 578 N. Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D74486 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D74486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Windsor Mill Rd & Forest Ave St.; 28 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J Shaffer

(Residence in Baltimore: No. Windsor Mill Rd & Forest ave St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Aug 31, 1840 (Month) (Day) (Year)

7-AGE, 82 yrs. 7 mos. 3 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Stonemason
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Shaffer

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan Schneider

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm G Shaffer

(Address) Windsor Mill Rd

15- Filed APR 5 - 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 27th 1923, to April 4th 1923, that I saw him alive on April 4th 1923, and that death occurred, on the date stated above, at 8.45 A.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 1 hour

CONTRIBUTORY (Secondary) High Blood Pressure

Apoplexy (Duration) .... yrs. 1 hour ds.

(Signed) Geo J Eversbaird M. D.

4/4/....., 1923 (Address) Woodlawn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Manchester Md — DATE OF BURIAL, April 7, 1923

20-UNDERTAKER H M Rowton — ADDRESS 223 W Main St Westminster

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks. JOHN B. NORWOOD

D74487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D74487

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 S Parrish ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Norwood

(a) RESIDENCE NO. 331 S Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15, 1860.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Norwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) America

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) America

14 Informant Miss Agnes Norwood

(Address) 512 Cleland Rd

15 APR 5 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to April 4, 1923,

that I last saw h... alive on April 4, 1923.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw T Coolahan, M. D.

4/5, 1923 (Address) 211 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park.

DATE OF BURIAL April 7 1923.

20 UNDERTAKER Geo L Schmidt

ADDRESS 2101 Eutaw Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D74488 HEALTH DEPARTMENT—CITY OF BALTIMORE D74488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Brooklyn 74-001 Registered No.

City of BALTIMORE: (No. 334 Maryland ave St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Schultz

(a) Residence No. 334 Maryland ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jennie H. Schultz

6-DATE OF BIRTH (month, day and year) July 11th 1869

7-AGE. 53 yrs. 8 mos. 23 ds.

If LESS than 1 day, hrs. or mtn.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Florist

(b) General nature of Industry, business, or establishment in which employed (or employer): Florist

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS:

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Celestia Parker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14-

(Informant) Jennie H. Schultz

(Address) 334 Maryland ave Brooklyn

15-Filed APR 5 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3rd 1923

17- I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to April 3rd, 1923, that I last saw him alive on April 2nd 1923, and that death occurred, on the date stated above, at 3P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage. Left side Paralysis of Right side

(Original hemorrhage Nov 15 1918) with 1 or 2 strokes since that date.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) gradual deepening paralysis

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? 314 S. Washington St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Johns Hopkins Hospital

(Signed) K. J. Hardy M. D.

(Address) 1202 N. Eden St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Colonial Cemetery Baltimore Co

DATE OF BURIAL, Apl 5th 1923

20-UNDERTAKER: Geo. Weber & Son

ADDRESS 2503 Edmondson ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74489

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-001 D74489

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1818 Linden ave St. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Caimes

(Residence in Baltimore: No. 1818 Linden ave St.; 2 mos. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: July 18 (Month) (Day), 1841 (Year)

7 AGE: 81 yrs. 8 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9 BIRTHPLACE (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Nelson Merryman

11 BIRTHPLACE OF FATHER (State or country): Balto Co. Md.

12 MAIDEN NAME OF MOTHER: Sarah Davis

13 BIRTHPLACE OF MOTHER (State or country): Balto Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Celia Caimes (Daughter)

(Address) 1818 Linden ave.

15 Filed APR 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 4th (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 25th, 1923 to April 4th 1923
that I saw her alive on April 4th 1923
and that death occurred, on the date stated above, at 4.30 P m.
The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) 4 yrs. mos. ds

Contributory (SECONDARY) Bronchitis

(Duration) 22 yrs. 2 mos. ds.

(Signed) William Muessick M. D.

April 5th 1923 (Address) 1700 Linden ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Bethel Cem Harford Co — DATE OF BURIAL: 4/7/23, 191

20 UNDERTAKER: E G Hentz & Son — ADDRESS: Jarrettsville Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74490 HEALTH DEPARTMENT—CITY OF BALTIMORE D74490

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1615 W Lexington St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Majorie Burrell

(Residence in Baltimore: No. 1615 W Lexington St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1920 (Year)

7-AGE. 3 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Sidney Burrell

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Sophia Hall

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sidney Burrell

(Address) 1615 W Lexington

15- Filed APR 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(over)

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Spasmodic Croup

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Benson M. D.

(Coroner.)

April 5 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual resilence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	April 5 1923
20-UNDERTAKER. James H. Dunn	ADDRESS 1303 Gilmor

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74491

CERTIFICATE OF DEATH.

D74491

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 E Chase ST., 8 WARD)

2-FULL NAME Mrs H. Fisher

(a) RESIDENCE NO. 2117 E Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Eliza F. Fisher

6 DATE OF BIRTH (month, day, and year) June 15-43

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Old

(b) General nature of industry, business, or establishment in which employed (or employer) Cabinet

(c) Name of employer Maker

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER ~~Henry D.~~ H. D. Froker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Germany

12 MAIDEN NAME OF MOTHER Christina Rover Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Germany

14 Informant Eliza F. Fisher

(Address) 2117 E Chase

15 Filed APR 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to April 3, 1923, that I last saw him alive on April 2, 1923, and that death occurred, on the date stated above, at 5.05 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H P Herzog M.D., M. D.

1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U. S. National

DATE OF BURIAL 4/5 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74492

CERTIFICATE OF DEATH.

99-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3) Woodlea Ave St., Gardenville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Springer

(a) RESIDENCE NO. 3) Woodlea Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of late Valentine Springer

6 DATE OF BIRTH (month, day, and year) Jan 30/36

7 AGE: Years 87 Months 2 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs F. M. Newkirk

(Address) 3) Woodlea Ave

15 Filed APR 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24 1923 to April 4 1923

that I last saw him alive on April 4 1923

and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Old age & acute bronchitis

10

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Young Cotter M.D.

, 19 (Address) 33 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL 4/8 1923

20 UNDERTAKER Philip Henry Orleans — ADDRESS 3016

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spc—12-23-21—E.B.R.S.—400 Bks.

D74493

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74493

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William Staten

(a) Residence No. ~~1224~~ 124 W. ontgomery St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1855

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook 21

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Cambridge, Md.

PARENTS.

10-NAME OF FATHER. Wm. Staten

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Cambridge, Md.

12-MAIDEN NAME OF MOTHER. Lecrescia Harris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Cambridge Md.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed APR 5 - 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 2 19 23 to April 3 19 23.

that I last saw him alive on April 2 19 23.

and that death occurred, on the date stated above, at 8:40 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. a Nicks M. D.

4-1-. 19 23 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Ct	April 6, 1923
20-UNDERTAKER.	ADDRESS
F. W. Bloomquist Son	708 W. Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D74494

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 W. Henrietta St. ST., 23 WARD)

2-FULL NAME Dorothy Viola Johnson

(a) RESIDENCE NO. 203 W. Henrietta. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		One	nine	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Brown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Bertha Johnson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Bertha Johnson

(Address) 919 Pleasant Alley

15 Filed APR 5 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1923, to April 4, 1923, that I last saw her alive on April 4, 1923, and that death occurred, on the date stated above, at 4.40 P.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convultions.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. Carwell, M. D.

4/5/1923 (Address) 740 W. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. auburn ct	April 6 1923
20 UNDERTAKER	ADDRESS
S. F. Brown & Son	1011 W. Pratt St

Spec- 12-23-21-E.B.R.S.--400 Blks.

Dobson

D74495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D74495

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 717 Little George St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Dobson

(a) Residence No. 717 Little George St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Dobson

6-DATE OF BIRTH (month, day and year) July 30 1883

7-AGE. 40 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shiping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Dobson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Louisa Barba

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Francis Dobson wife

(Address) 717 Little George St.

15- Filed APR 5 - 1923 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from December 30, 19 22 to April 3, 19 23

that I last saw him alive on April 3, 19 23

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Johnson Hd

(Signed) John K Cooley M. D.

, 19 (Address) 712 George St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) **whether Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem	April 7... 19....

20-UNDERTAKER. Mrs K. Elliott

ADDRESS 1763 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74496

11-001 D74496

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2827 Robe Ave Graus ST.: 17 WARD)

2-FULL NAME Carl Maynard Mathews

(a) RESIDENCE. NO. 2827 Robe ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married,~~ Widowed, or Divorced (write the word)
Male	Col	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Walter Matthews
(Address) 2827 Robe ave

15 APR 5-1923 ROBERT R. KRAMER, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 - 1923

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 4, 1923, that I last saw him alive on April 3, 1923, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Probable Influenza

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Ogden Burns, M. D.

, 19 (Address) 1 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Cemetery Forest Hill	1923
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74497

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D74497 Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Patterson

(a) Residence No. Bay View Asylum. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1847

7-AGE.	If LESS than 1 day,
75 yrs. ... mos. ... ds.	... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Caulker

(b) General nature of Industry, business, or establishment in which employed (or employer): O'b

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wm. Patterson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Hattie Person

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Municipal Hospital Records

(Address)

15- APR 5 - 1923 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk. Commissioner Health.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 30, 1923, to April 1, 1923

that I last saw him alive on March 31, 1923

and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ... yrs. ... mos. 5 ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

4-2- , 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19....
20-UNDERTAKER.	ADDRESS

APR 4 - 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1)2

Spec.—1-10-21—M&T—1500 Bks.

D74498

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74498

CERTIFICATE OF DEATH.

45

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST. WARD)

2-FULL NAME Sandora [redacted] Keeley

(a) RESIDENCE NO. 1917 E Pratt ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ ~~(or) WIFE of~~ Peter J Keeley

6 DATE OF BIRTH (month, day, and year) Jan 16th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	77	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Flaherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Flaherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ella Keeley
(Address) 1917 E Pratt St.

15 APR 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1923

I HEREBY CERTIFY That I attended deceased from March 22, 1923, to April 2, 1923, that I last saw ~~her~~ alive on April 2, 1923, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma Rectum.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of March 23, 1923.

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Shumick, M. D.

19 Address St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	4/6 1923
20 UNDERTAKER J. G. Moran	ADDRESS 600 E Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74499

REGISTERED NO. D74499

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 Gallagher Ct. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WALENTY ZARZYCKI,

(a) RESIDENCE NO. 2307 Gallagher Ct. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Widowed,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Waleria Zarzycki,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring at home,

(b) General nature of Industry, business, or establishment in which employed (or employer) 680

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Umknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pland,

14 Informant M. F. Sadowski. for Bronislawa (Address) 43040 Hudson St. Grudzynzaki.

15 Filed APR 5 1923, 19 Robert F. Hartsock, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to April 4, 1923, that I last saw h— alive on April 4, 1923, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic aortic insufficiency

(duration) one year mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank A. Jaworski, M. D.

4/5, 1923 (Address) 2431 Fleet

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery, DATE OF BURIAL: April 7 1923.

20 UNDERTAKER: M. F. Sadowski. ADDRESS: 705 S. Ann

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. E... item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74500

CERTIFICATE OF DEATH.

100-001

D74500

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 2 Register ST., 7 WARD)

2-FULL NAME. Angelina Kropp

(a) RESIDENCE NO. 411 2 Register ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Benjamin Kropp

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Bronislawa .....

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) Poland

14 Informant M. F. Sadowski
(Address) 705 S. Ann St.

15 Robert P. Harrison, Registrar
APR 5 1923 .19.....
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1923

17

I HEREBY CERTIFY, That I attended deceased from 4/1, 1923, to 4/4, 1923, that I last saw h alive on 4/4, 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobular Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay H Bruchey, M. D.

4/5, 1923 (Address) 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL April 6, 1923

20 UNDERTAKER M. F. Sadowski. ADDRESS 705 S. Ann

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74501

1-PLACE OF DEATH

City of BALTIMORE: (No. 2245 Eastern Ave St., Ward)

Registered No.....

2-FULL NAME Mrs Louisa Henry

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2245 Eastern Ave St., Ward Seven Valleys Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of David Henry

6-DATE OF BIRTH (month, day and year) Dec 16 1842

7-AGE, 80 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), York New Salem Penn.

PARENTS.

10-NAME OF FATHER, Henry Zellers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Mary Walters.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

14- (Informant) Mrs L. Richards

(Address) 2245 Eastern Ave

15- Robert P. Harrison,

Filed ....., 192.... Registrar.

Burial Permit Clerk.

APR 5 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 5 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb. 2 1923 to April 5 1923

that I last saw her alive on April 4 1923

and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Carbuncle.

(Duration) ....yrs. 2 mos. ....ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. S. Neer, M. D.

4/5/23 (Address) 408 S. Paca Park Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Seven Valley's Penn'a. DATE OF BURIAL, April 7 1923.

20-UNDERTAKER, H Heemann. ADDRESS 320 Broadway.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D74502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74502

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 N. Gilmor ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth B. Nicklas

(a) RESIDENCE. No. 812 N. Gilmor 1 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 4-1857

7 AGE 65 Years Months 10 Days If LESS than 1 day, hrs. or min.

June 4 1857

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Casper Nicklas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mary C. Barranger 812 N Gilmor St.

APR 5 - 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 3- , 1923, to Apr 4 , 1923, that I last saw h alive on Apr 4 , 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) None known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys - exam.

(Signed) Chas. J Keller, M. D.

, 19 (Address) 222 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Apr 7 1923

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins st

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74503

CERTIFICATE OF DEATH.

161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stuart See Coquenberly

(a) Residence No. 1318 Eutaw Place St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 3-27-23

7-AGE. ....yrs. ....mos. 9 ds. If LESS than 1 day, ...hrs. or. ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Isaac Wedderburn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER, Adelaide Murray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ohio

14- (Informant) Hosp Record

(Address)

15- Robert J. Harrison,

Filed ....., 192.... Registrar.

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-5-23

17- I HEREBY CERTIFY, That I attended deceased from 3-27 19 23 to 4-5 19 23

that I last saw h... alive on 4-5 19 23

and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH was as follows:

Pneumonia

Bert

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Germ + Sputum

(Signed) S. J. Crenshaw M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 4-6-23

20-UNDERTAKER Gryck & Linky ADDRESS Sulton & Smyth

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 5

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74504

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1322 Harlem Ave. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Wilson

(a) RESIDENCE. NO. 1322 Harlem Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------- Wilson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer) Maid

(c) Name of employer Dr. Edward A. Morgan

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dr. Edward A. Morgan
(Address) 1322 Harlem Ave.

15 APR 5 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to April 4, 1923, that I last saw h.r alive on April 4, 1923, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A Morgan, M. D.

, 19 (Address) 1322 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: April 6, 1923

20 UNDERTAKER: Harry N. Witzke — ADDRESS: 1531 W. Lombard St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—

Spec.—1-10-21—M&T—1500 Bks.

D74505

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74505

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 14 ST., Frederica WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. ~~Nathan~~ Gutman

(a) RESIDENCE NO. 2127 Linden Ave, Balto ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Nathan Gutman

6 DATE OF BIRTH (month, day, and year) December 6th, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Weil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bettie Kayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp. Records.

(Address)

15 Filed Robert P. Harrison, Registrar

APR 5 1923

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th 1923

17

I HEREBY CERTIFY, That I attended deceased from March 12th, 1923, to April 4th, 1923, that I last saw her alive on April 4th, 1923, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency - terminal failure

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute appendicitis, ruptured with abscess. (duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of March 12th

Was there an autopsy? no

What test confirmed diagnosis? Clinical course + operation.

(Signed) Jno. F. Hiney, M. D.

April 5th 1923 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	4/6 1923
20 UNDERTAKER	ADDRESS
David Sondheim	118 W. Mt. Royal Ave.

Spec.—1-10-21—M&T—1500 Blks.

D74506

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74506

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Eutaw Place St., 14 WARD)

2-FULL NAME ADDIE AMBACH.

(a) RESIDENCE NO. 1716 EUTAW PLACE ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	WIDOW

5a If married, widowed [redacted] of (or) WIFE of [redacted] MAX AMBACH 1856

6 DATE OF BIRTH (month, day, and year) DEC. 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67.	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 000

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) COLUMBUS. O.

PARENTS

10 NAME OF FATHER JOS. GUNDERSHEIMER

11 BIRTHPLACE OF FATHER (city or town) (State or country) GERMANY

12 MAIDEN NAME OF MOTHER ESTHER GREENBAUM

13 BIRTHPLACE OF MOTHER (city or town) (State or country) GERMANY

14 Informant Henry Ambach (Address) Emelsonian Apts.

15 Robert P. Harris, M.D. Registrar

APR 5 1923

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan ..., 1922 ..., to April 4 ..., 1923 ..., that I last saw her alive on April 4th ..., 1923 ..., and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myo. carditicis

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary edema; Acute Nephritis

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Michael A. Adams M. D.

, 19 (Address) 360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	4/6/ 1923
20 UNDERTAKER David Londheim	ADDRESS 1181 W. Mt. Royal Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74507

CERTIFICATE OF DEATH.

D74507

117

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 20 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin E Lundquist.

(a) RESIDENCE NO. 2318 W. Fayette St., ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Annie Mary Lundquist

6 DATE OF BIRTH (month, day, and year) July 1st 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist.
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Lundquist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant University Hosp Records
(Address)

15 APR 5 1923 Robert P. Harrison, ... 19 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 4 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/31 1923, to 4/4 1923, that I last saw him alive on 4/4 1923, and that death occurred, on the date stated above, at 6:35P. m.

The CAUSE OF DEATH* was as follows:

St Micaeniq and Peritonitis (acute)
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Ruptured Appendix
(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) ~~Wallace~~ [illegible] M. D.

APR 4 1923 (Address) University Hospital or Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park

DATE OF BURIAL APR 7 1923

20 UNDERTAKER Geo N Little

ADDRESS 2700 EDMONDSON AVE.

DO NOT WRITE IN THIS SPACE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74508

HEALTH DEPARTMENT—CITY OF BALTIMORE

#6 D74508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5239 St Charles Ave (St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M- Farrell

(a) RESIDENCE No. 5239 St Charles Ave (St.) (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced (Husband of) (or) WIFE OF John - H- Farrell

6 DATE OF BIRTH (month, day, and year) Feb 17

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Mays Co Md

PARENTS

10 NAME OF FATHER John H Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Nellie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Mays Co. Md

14 Informant Edward Cohn

(Address) 5239 St Charles Ave

Filed APR 5 1923, 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1922 to Apr. Mar, 1923.

that I last saw her alive on Mar, 1923

and that death occurred, on the date stated above, at 8 05 P.M.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1901 Chase St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Edestell, M. D.

4/4, 1923 (Address) Henry Russell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem Lutheran

DATE OF BURIAL 19

20 UNDERTAKER Wm Cook.

ADDRESS 532 E Baltimore Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74509

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74509

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Boyview Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

2-FULL NAME Augusta Bunch

(a) RESIDENCE NO. 1750 Gorsuch Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Cent Cleland Mary Land

10 NAME OF FATHER George J. Bunch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Boyview Hospital (Address) Baltimore, Md.

15 Robert J. Harrison, Registrar

APR 5 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923 to April 4 1923

that I last saw h[illegible] alive on April 4 1923

and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency, Mixed Type

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Pathological

(Signed) N. Redmond Taylor, M. D.

4/5/1923 (Address) Boyview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: April 9, 1923

20 UNDERTAKER: Wm. Leo[illegible] ADDRESS: 502 E. Nor[illegible] Ave

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16233 D74510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 D74510

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Paul M. Allen.

(a) RESIDENCE NO. Surry, S. C. ST., WARD

(Usual place of abode) (ii non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Mrs Hannah H. Allen.

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1864.

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
59	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer. Ret'd

(b) General nature of industry, business, or establishment in which employed (or employer) (+?)

(c) Name of employer (+?)

9 BIRTHPLACE (city or town) ..... (State or country) S. C.

PARENTS

10 NAME OF FATHER John C. Allen.

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) S. C.

12 MAIDEN NAME OF MOTHER Sarah Tyson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) S. C.

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Hospitals.

APR 5 1923 Robert J. Happersett, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March 21. 1923. to April 5, 1923. that I last saw him alive on April 5 1923, and that death occurred, on the date stated above, at 10:00 A. M.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of March 31, 23

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Allendale S. C. DATE OF BURIAL April 5, 1923

20 UNDERTAKER Wm. Leo & Son ADDRESS for E. Monument Sq

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74511

CERTIFICATE OF DEATH.

X31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lincoln Ave near Fanny Road ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Marie Hale

(a) RESIDENCE NO. Lincoln Ave ST., 27 WARD Philadelphia Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Gilbert H. Hale

6 DATE OF BIRTH (month, day, and year) July 10, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trained nurse

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 048

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Hugh J. Conroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Gilbert H. Hale
(Address) Lincoln Ave

15 Filed APR 5 1923, 19 ... Registrar
Robert J. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1923, to April 5, 1923, that I last saw her alive on April 4, 1923, and that death occurred, on the date stated above, at 12.20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
about (duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Philadelphia Pa

Did an operation precede death? no Date of ...

Was there an autopsy? no T.B. found

What test confirmed diagnosis? ...

(Signed) Warren J. Todd, M. D.

4-5, 1923 (Address) 1 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: April 7, 1923

UNDERTAKER: A S Marshall — ADDRESS: 3539 Falls Rd

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74512

CERTIFICATE OF DEATH.

D74512

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Mosling Ave ST., 13 WARD)

2-FULL NAME E. Monroe Simonson

(a) RESIDENCE NO. 1412 Mosling Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 29 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Belle Simonson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Mary Anderson (Address) 1412 Mosling Ave

15 Date APR 5 1923 Robert J. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to April 4, 1923, that I last saw h[illegible] alive on April 4, 1923, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition - Tuberculosis

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 12 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Vernon F. Keely, M. D.

4/5, 1923 (Address) 3702 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden Md DATE OF BURIAL 4 6 1923

20 UNDERTAKER: A S Marshall ADDRESS 3539 Falls Road

WARNING—RESERVED FOR REGISTRAR'S USE

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74513

CERTIFICATE OF DEATH.

31 D74513

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4303 N. Charles St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernst Schmeisser

(a) Residence No. 4303 N. Charles St., 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 55 yrs. 2 mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Schmeisser

6-DATE OF BIRTH (month, day and year) March-9-1851

7-AGE. 72 yrs. 0 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer (none)

9-BIRTHPLACE (city or town) Siegen
(State or Country) West Phalia - Germany

PARENTS.

10-NAME OF FATHER Christian Schmeisser

11-BIRTHPLACE OF FATHER (city or town) Siegen
(State or Country) Germany

12-MAIDEN NAME OF MOTHER, Mariana Dressler

13-BIRTHPLACE OF MOTHER (city or town) Siegen
(State or Country) Germany

14-

(Informant) Mr. Wm. C. Schmeisser son

(Address) 4303 N. Charles St.

15-FILED APR 6 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 5/23

17- I HEREBY CERTIFY, That I attended deceased from March 27 1923, to April 5, 1923, that I last saw h. alive on April 4, 1923, and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D

19 (Address) 1702 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery

DATE OF BURIAL, Apl 7, 1923

20-UNDERTAKER STEWART & MOWEN COMPANY
WILLIAM F. WOODEN, Successor

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D74514

CERTIFICATE OF DEATH.

D74514

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nancy D. Adams

(Residence in Baltimore: No. Homewood Hospital St.; 50 yrs. 0 mos. 0 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, June (Month) 25 (Day) 1840 (Year)

7-AGE, 82 yrs. 3 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country), Michigan

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country) not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country). not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Esmer (non-relative)

(Address) Harrisburg Pa.

15- Filed APR 6 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1922, to June 4 1923, that I saw h alive on June 4 1923, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(Duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastritis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

4/5, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 9 mos. 0 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at place death

Former or usual residence Homewood Hospital.

19-PLACE OF BURIAL OR REMOVAL. Clinton-Michigan

DATE OF BURIAL April 6 1923

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

162512 11

D74515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74515

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Beck

(a) RESIDENCE NO. Winona Apts. City ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 53 yrs. 1 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mrs Mary Beck (wife),

6 DATE OF BIRTH (month, day, and year) Feb 15-1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	53.	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer. Atty

(b) General nature of industry, business, or establishment in which employed (or employer): (")

(c) Name of employer: (")

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Samuel Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellen Constable

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records.

15 APR 6 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24 1923 to April 5 1923, that I last saw him alive on April 5 1923, and that death occurred, on the date stated above, at 4 15 a. m.

The CAUSE OF DEATH* was as follows:

Acute miliary tuberculosis

(duration) ... yrs. mos 12 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown - Md

DATE OF BURIAL: Apr 7 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

D74516

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

45 D74516

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 20 WARD)

2-FULL NAME Mrs. Elizabeth Reibe.

(a) RESIDENCE NO. 1914 W. Franklin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write this word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 7 1856

7 AGE Years 67 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Gustaf Koethe

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unk Unk

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Michael Reibe (Address) 1914 W Franklin St

15 Filed APR 6 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/23 19

17 I HEREBY CERTIFY, That I attended deceased from Mar 25, 1923, to Apr 5, 1923,

that I last saw her alive on Apr 5, 1923,

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid.

? (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes, Date of Laparotomy 3/25/23

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Chas Wilbur Stewart M. D.

4/5, 1923 (Address) 1738 E. 28th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Inc

DATE OF BURIAL Apl 7 1923

UNDERTAKER Robt Johnson

ADDRESS 1742 W. Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74517

CERTIFICATE OF DEATH.

202 D74517

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto city Jail St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bishop Hawkins

(a) RESIDENCE. No. Unknown St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: 44 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant Keep Jail
(Address)

15 APR 6 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1923, to Apr 6, 1923, that I last saw him alive on Apr 6, 1923, and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Hanging by the neck

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dislocation Cervical Vertebrae (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. J. Towers, M. D.

, 19 (Address) 926 N. Chester

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patricks Cemy — DATE OF BURIAL: April 6 1923

20 UNDERTAKER: Wm Ellis & Son — ADDRESS: 1737 N Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D74518

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D74518

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Raymond Jackson

(Residence in Baltimore: No. 434 N Fremont St St.; yrs. 30 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col.	Married

6-DATE OF BIRTH, ... Don't Know (Month) (Day) ....., 1..... (Year)

7-AGE, 41 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER, (State or Country). , ,

12-MAIDEN NAME OF MOTHER, , ,

13-BIRTHPLACE OF MOTHER, (State or Country). , ,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie Legdusan

(Address). 434 N Fremont St

15- FILED APR 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ~~his~~ death ~~by~~ as ~~inquiry.~~ on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) Don't Know ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. H. Jones M. D. (Coroner.)

4-5 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Bay View Cemetery	April 7 1923
20-UNDERTAKER, Edward Bryan	ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74519

CERTIFICATE OF DEATH.

31 ✓ D74519

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 n-Pine ST., 4 WARD)

2-FULL NAME Edna Dixon

(a) RESIDENCE No. 306 n-Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ[illegible] 28 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: feaml

4 COLOR OR RACE: colord

5 Single, Married, Widowed, or Divorced (write the word): Singl.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: singel

6 DATE OF BIRTH (month, day, and year): may 9. 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house. work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Daniel Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Savage

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Savage

(Address): 306 [illegible] St

15 APR 6 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-4-1923

17 I HEREBY CERTIFY, That I attended deceased from 1-4-, 1923, to 4-4-, 1923, that I last saw her alive on 4-2-, 1923, and that death occurred, on the date stated above, at 4,25 A m.

The CAUSE OF DEATH* was as follows: Tuberculosis of lungs

(duration) Indefinate yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Just Carpet, M. D.

4-4-, 1923 (Address) 611 - n - Carol

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery — DATE OF BURIAL: april 6 1923

20 UNDERTAKER: Edward Bryon — ADDRESS 1631 orleans st

—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated CAREFULLY. Exact statement of Space. mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Lockley

D74520 ✓ D74520

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 Franklin ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Lockley

(a) RESIDENCE. No. 841 Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 17 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Cecil Lockley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Chasa Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Lucy Lockley

(Address) 841 Franklin

15 Filed APR 6 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 16 1923, to Apr. 4 1923

that I last saw him alive on Apr. 4 1923,

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Mavis Edmondson, M. D.

(Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Pond Co. DATE OF BURIAL Apr 7 1923

20 UNDERTAKER Samuel H. Chase Son ADDRESS 1400 Druid

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74521

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2544 Mace ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter M. Pinder

(a) RESIDENCE. NO. 2544 Mace ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md.

PARENTS

10 NAME OF FATHER Thomas W Pinder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Sarah Wangus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant (Address) Thomas W Pinder 2544 Mace St

15 [illegible]

APR 6-1923

ROBERT E. KRAUTER,
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from August, 1923, to April 4, 1923, that I last saw him alive on April 2, 1923, and that death occurred, on the date stated above, at 12.40 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Does not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Brown Pratt M. D.

4/5. 1923 (Address) 2436 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL April 6 1923

20 UNDERTAKER Joseph A Farrell

ADDRESS 2319 Division St

B. WRITE PLAINLY. Words should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C..... 185 D74522

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Tilghman

(Residence in Baltimore: No. 113 W Mulberry St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Single

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE. 62 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balt. City.

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER, (State or Country). Not Known

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER, (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice D. Tilghman

(Address) 113 W. Mulberry St

15- FILED APR 6 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 4 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractures & bruises by fall on street accident

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) James M. Reuter M. D. (Coroner.)

April 5 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. mos. 14 ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?..... Accident on Mosher

Former or usual residence 113 W Mulberry

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. April 6th 1923

20-UNDERTAKER. Henry W. Jenkins & Co. ADDRESS Orchard & Collington Sts

N. B.—Every item of information should be carefully supplied. Age should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74523

CERTIFICATE OF DEATH.

164 D74523

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Hilldale Av ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmine Rau

(a) RESIDENCE NO. 2811 Hilldale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John C Rau

6 DATE OF BIRTH (month, day, and year): Sept 26-1831

7 AGE — Years: 91 Months: 6 Days: 7 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Schlendorf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Wm Rau

(Address) 2811 Hilldale Av

15 Filed APR 6 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 7 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 4, 1923, that I last saw h[illegible] alive on April 2 1923, and that death occurred, on the date stated above, at 8 00 a.m.

The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E Lee Cronshaw M. D.

4/9, 1923 (Address) 817 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel — DATE OF BURIAL: Apr 8 1923

20 UNDERTAKER: John Zellers — ADDRESS: 2205 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied. AGE should be carefully supplied. AGE should be properly classified

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74524

D74524

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3513 E Lombard ST., 26 WARD)

2-FULL NAME Margaret Hughes

(a) RESIDENCE NO. 3513 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Hughes

6 DATE OF BIRTH (month, day, and year) 9-4-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Louis D Minick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Klinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Hughes (Address) 3513 E Lombard

15 APR 6 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1923, to April 5, 1923, that I last saw h[illegible] alive on April 4, 1923, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Paranoid Neurasthenia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Dr Schneider M. D.

1923 (Address) 330 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Col Town Cem

DATE OF BURIAL Apr 7 1923

20 UNDERTAKER John Sullivan

ADDRESS Rock Allegan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. AGE, if under 1 year, should be stated in days, so that it may be properly classified. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Marie Nohe

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74525

CERTIFICATE OF DEATH.

162 D74525

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27.3 Hare ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Nohe

(a) RESIDENCE. No. 27.3 Hare ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 02 1920

7 AGE: Years — Months — Days — If LESS than 1 day, hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew Nohe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Marie Neary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Andrew Nohe (Address) 27 S. Hare

15 Filed APR 6 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-5 1923 to 4-5 1923 that I last saw her alive on 4-5 1923 and that death occurred, on the date stated above, at 12.30A m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4-5 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Apr 6 1923

20 UNDERTAKER: John Ulrich — ADDRESS: 2405 Eastern.

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL BLANKS should be stated EXACTLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1925-001

D74526

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Willis

(a) Residence No. 1420 W. Mulberry St. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: John T. Willis

6-DATE OF BIRTH (month, day and year): 1867

7-AGE: 55 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: ?Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ? Md.

12-MAIDEN NAME OF MOTHER: Unknown ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ? Md.

11- (Informant) Municipal Hospital Records

(Address) .....

15- FILED APR 6 - 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 4, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 31 1923 to April 4 1923.

that I last saw her alive on April 3, 1923.

and that death occurred, on the date stated above, at 4:40 A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) ? yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Llewellyn M. D.

4-4 1923 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Westlego Cemetery

DATE OF BURIAL: April 6th, 1923

20-UNDERTAKER: John E. Bowman & Chas. H. Howard

ADDRESS 901 Hollins St.

N. B.—WRITE PLAINLY. WITH UNFAMILIAR NAMES, SPELL EXACTLY. PHYSICIAN'S OFFICE ADDRESS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. Cause of death should be properly classified. Use only such terms as are in accordance with instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74527 100-001 D74527

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 873 W Fayette St - ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Anderson

(a) RESIDENCE. No. 873 W Fayette St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Febry 11th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Wildow Anderson

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Lizzie Breen

13 BIRTHPLACE OF MOTHER (city or town) Maryland.
(State or country)

14 Informant Mrs Irene Breen Anderson
(Address) 873 W Fayette St.

15 Filed APR 6 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4th 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 1. 1923, to Apr. 4. 1923, that I last saw her alive on Apr 4. 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchs - Pneumonia (Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Signs

(Signed) J. Thurston Ford, M. D.

. 19 (Address) 1288 N. Luzerne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery.	Apr 6th 1923

20 UNDERTAKER John J. Bowers & Son

ADDRESS 901 Holbrook St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Rks.

Permission given to keep remains until April 10/23

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74528

CERTIFICATE OF DEATH.

REGISTERED D74528

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 904 N Patterson Park Ave St., 7 WARD)

2-FULL NAME Mary E Roth.

(a) RESIDENCE NO. 904 N Patterson Park Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of: Charles E Roth.

6 DATE OF BIRTH (month, day, and year): Sept. 12th 1857

7 AGE: Years 65, Months 6, Days, If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Dennis Splain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Loftes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Splain (Address) 904 N Patterson Park Ave

15 Filed APR 6 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from October, 1922, to April 4, 1923, that I last saw her alive on April 3, 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Paresis. Tertiary

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Mental

(Signed) Milton P Hill, M. D.

, 19 (Address) 609 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: April 10 1923

20 UNDERTAKER: Geo M. Hirth Son

ADDRESS: 811 N Howard St

N. B.—WRITE PLAINLY, WITHOUT ABBREVIATIONS. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. EMPLOYER'S NAME AND ADDRESS. Information should be carefully supplied

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Syphilis

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74529

CERTIFICATE OF DEATH.

D74529

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Isaac of the St. 10 WARD)

2-FULL NAME Peter McGovern.

(a) RESIDENCE NO. Preston & Valley Sts. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kearney.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About 69 Unknown				

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick McGovern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ...

14 Informant Helen Florence (Address) Preston & Valley Sts.

15 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

APR 6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from ... 19 ... to ... 19 ...

that I last saw h... alive on April 1 1923.

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

a Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) F. A. Wagner, M. D.

April 5, 1923 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents — DATE OF BURIAL 4-7 1923

20 UNDERTAKER E. B. Hanle — ADDRESS 115 E. West St.

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74530

CERTIFICATE OF DEATH.

101-001

D74530

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 Oakdale Road ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel P. Robinson

(a) RESIDENCE NO. 301 Oakdale Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma L. Robinson

6 DATE OF BIRTH (month, day, and year) Dec 28-66

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager Clo

(b) General nature of industry, business, or establishment in which employed (or employer) Continental

(c) Name of employer Gun Co.

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emma L. Robinson
(Address) 301 Oakdale Rd

15 APR 6 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1923

17 I HEREBY CERTIFY, That I attended deceased from 30 Mar 1922, to 4 Apr 1923

that I last saw him alive on 4 Apr 1923

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hyaline congestation

(Signed) D S Smoot, M. D.

, 19 (Address) 301 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chicago Ill. DATE OF BURIAL Apr 6 1923

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—This page is to be filled in COMPLETELY. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7H-001

D74531

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1023 W. 36 St St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kershaw

(a) Residence No. 1023 W 36 St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-~~Single, Married~~ Widowed, ~~or Divorced~~, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A Kershaw

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER John Briley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) James B. Kershaw

(Address) 1023 W 36 St

15- Filed APR 6 - 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apl 5-1923

17- I HEREBY CERTIFY, That I attended deceased from April 2nd, 1923 to April 4th, 1923

that I last saw h[illegible] alive on April 4th 1923

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) — yrs. — mos. 4h ds.

CONTRIBUTORY (Secondary) Asthma of Long st

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

, 19 (Address) 2919 Huntington Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden | DATE OF BURIAL, Apl 7, 1923

UNDERTAKER Chenoweth Son ADDRESS Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D74532

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Richardson

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed APR 6-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1916 to April 3, 1923, that I last saw h.. alive on April 3, 1923, and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Infirmities

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

4-4-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: April 7 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY: mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74533

D74533

CERTIFICATE OF DEATH.

Registered No. 6129

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 N Calhoun St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Louisa M Zimmisch

(a) Residence No. 705 N Calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. W F | 4-COLOR OR RACE, W | 5-Single, Married, Widow, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederic

6-DATE OF BIRTH (month, day and year) Oct 5 1857

7-AGE, 68 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer). Off

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balt.

PARENTS.

10-NAME OF FATHER, Louis Kuhn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Selma

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs L Zimmisch

(Address) 705 N Calhoun St

15- Filed APR 6-1923 19 Robert R. Krauter, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/4/23

17- I HEREBY CERTIFY, That I attended deceased from Jan 21, 1923 to Apr 3, 1923

that I last saw h.. alive on Apr 3, 1923

and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

Colv. ulcer. nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Homer C. Todd M. D.

4/4, 1923 (Address) 735 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park | DATE OF BURIAL, April 6, 1923

20-UNDERTAKER. Wm Cook | ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH INK. ... should be stated EXACTLY. ... should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. ... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74534

CERTIFICATE OF DEATH.

90 D74534

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 104 S. Carey ST. 14 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie C. Childs

(a) RESIDENCE. NO. 104 S. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Samuel J. Childs

6 DATE OF BIRTH (month, day, and year) Feb 6. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER John P. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant Mr. John F. Childs
(Address) 104 S. Carey St.

15 Filed APR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 27 . 1923 . to April 4 . 1923 . that I last saw her alive on April 4 . 1923 . and that death occurred, on the date stated above, at 7-15 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis
(duration) Five weeks

CONTRIBUTORY (Secondary) Senile Arteriosclerosis and Myocarditis
(duration) Over 5 weeks

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry J. Childs M.D.

Apr 4 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Clare Cem	April 7 1923
20 UNDERTAKER	ADDRESS
William Cook	502 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. Exact statement of DECEASED'S mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74535

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74535

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 632 Fairfield st. ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilmer Fowler

(a) RESIDENCE NO. 632 First Street (West Pou) ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coalpasser

(b) General nature of Industry, business, or establishment in which employed (or employer) Marine

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER R. C. Fowler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Fowler

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant R. C. Fowler
(Address) 632 First st West

15 Filed APR 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-1923

17

I HEREBY CERTIFY, That I attended deceased from 3-22-, 1923, to 4-4-, 1923, that I last saw h— alive on 4-4-, 1923, and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis
(Pneumococcic)

(duration) yrs. mos 1 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Ex

(Signed) Newton D. Pere, M. D.

4/5/, 1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Prince George Co. Md

DATE OF BURIAL April 7 1923

20 UNDERTAKER Jenkins & Jenkins

ADDRESS 1734 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D74536

D74536

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 Brice St ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Morris (Wife of)

(Residence in Baltimore: No. 818 E Brice St St.; ....yrs., 11 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov. (Month) 16 (Day), 1851 (Year)

7-AGE, 71 yrs. 5 mos. 18 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... nothing
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Hall

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Hester Paisley

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Achill Morris

(Address) 818 Brice st

15-

Filed APR 6 - 1923 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 30 1923, to April 4 1923, that I saw her alive on April 4 1923, and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows:

Multiple Fibroma

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis and Dropsy

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. B. Conner M. D.

April 4, 1923. (Address) 1900 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 4 mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 818 E Brice St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park | DATE OF BURIAL, April 7, 191..

20-UNDERTAKER Josiah Spencer | ADDRESS Cedar north of Pre

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74537

CERTIFICATE OF DEATH.

D74537

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Ething ST., BOLDIN 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Bolden

(a) RESIDENCE No. 2102 Ething ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Edith P. Bolden

6 DATE OF BIRTH (month, day, and year) 11/20/1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Bolden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Waiche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edith Bolden

(Address) 2102 Ething St.

15 Filed APR 6 1923 . 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 31 . 1923 to Apr. 4 . 1923

that I last saw him alive on Apr. 3 . 1923

and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) John R. Tompkins, M. D.

19 (Address) 1912 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Apr. 6 1923

20 UNDERTAKER: Jas M. Johnson — ADDRESS 1234 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74538 HEALTH DEPARTMENT—CITY OF BALTIMORE D74538

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sheehan

(a) RESIDENCE. No. Mt Hope Retreat ST., 28th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Dead mos. ds. How long in U. S., if of foreign birth? Born in Ireland mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 12-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) (?) Ireland

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) (?)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) (?)

14 Informant Richard Mt Hope Retreat (Address) Mt Hope Md.

15 Filed APR 6-1923 ROBERT R. KRAUTER Registrar
Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1923, to Apr 5th, 1923, that I last saw h.e alive on Apr 4, 1923, and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Dest Senile
Atherosma -
abt (duration) yrs. 5 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -
abt (duration) 0 yrs. 5 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Apr 5, 1923 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	April 7 1923
20 UNDERTAKER	ADDRESS
Fred A. Krumm & Son	703 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D74539

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 609 Pierce Street ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Washington

(a) RESIDENCE. NO. 609 Pierce street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Washington

6 DATE OF BIRTH (month, day, and year) Aug 4, 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42	yrs	Eight	fours	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work labor, 040

(b) General nature of industry, business, or establishment in which employed (or employer) street labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester Va

PARENTS

10 NAME OF FATHER Taylor Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winchester Va

12 MAIDEN NAME OF MOTHER Eliza Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winchester Va

14 Informant Sadie Washington

(Address) 609 Pierce Street

15 Filed . 19 ROBERT R. KRAUTER, Registrar

APR 6-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2d 1923, to April 5th 1923, that I last saw him alive on April 5th 1923, and that death occurred, on the date stated above, at one P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Interlenticulate Striate Artery

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lorenzo B Evans, M. D.

, 19 (Address) 411 N Greene street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winchester Fredonick Co Va	April 7 1923
20 UNDERTAKER Inns Robert A Elliott	ADDRESS 1725 Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT EXACTLY. PHYSICIAN should be stated EXACTLY. INFORMANT should be careefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lks.

D74540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D74540

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Pine ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie Jane

(Residence in Baltimore: No. 511 N Pine St.: 30 yrs.. ..mos. ..ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1869 (Year)

7-AGE, 54 yrs. ..mos. ..ds. If LESS than 1 day, ..hrs. or ..min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER, Thomas Dungey

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Jane

(Address) 511 N Pine

15- Filed APR 6 - 1923, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 3 1923, to Apr 3 1923, that I saw her alive on Apr 2, 1923, and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..yrs. ..mos. ..ds.

(Signed) William E Burton M. D.

Apr 5, 1923 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Cold Water, Laurel Run Co DATE OF BURIAL, Apr 6, 1923

20-UNDERTAKER Samuel J Hemsley ADDRESS 778 N Eutaw

N. B.—Every item of information should be carefully supplied. AGE in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~D74541~~ 10 D74541

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. ..... ST., 14 WARD)

2-FULL NAME Eugene Washington

(a) RESIDENCE NO. 1515 Myrtle Ave City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or..... min.
		1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Millard -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed APR 6 - 1923, ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to April 4, 1923.
that I last saw him alive on April 4, 1923
and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) Nasal Diphtheria 14 ds. 3 days

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL April 1923

20 UNDERTAKER Brown & Taylor & Sehrt

ADDRESS 1140 N.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be stated EXACTLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Odell Stoval

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~1774~~ D74542 CERTIFICATE OF DEATH. STILL BIRTH NO. ~~1774~~ D74542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 East 28 St.: 9/16 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Odell Stoval

(a) RESIDENCE. No. 633 E 28 St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Bl	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 4. 1923

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Perry Stoval

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Ellie Hunter

13 BIRTHPLACE OF MOTHER (city or town) Georgia
(State or country)

14 Informant Perry Stoval
(Address) 633 E 28 St

15 Filed APR 6 1923, 19 ROBERT E. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5: 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1923, to Apr 5, 1923, that I last saw h— alive on Apr 5, 1923, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth, cause
Premature birth, cause
Period of uterine gestation
(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) R. Garland Schmidt M. D.

(Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	April 6 19 23

20 UNDERTAKER Mrs. R. C. Elliott ADDRESS 1720 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74543 ✓

D74543 REGISTERED NO. 129

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. St. Josephs Hospital ST., No WARD)

2-FULL NAME Wallace Jones.

(a) RESIDENCE NO. 1314 E. Eutaw ST., WARD

(Usual place of abode) 3403- (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Jones.

6 DATE OF BIRTH (month, day, and year) Sept. 14—1853.

7 AGE Years 69. Months 6 Days 22 If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Catherine Jones (Address) 3403 Elliott St.

15 Filed APR 6-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-1923

I HEREBY CERTIFY that I attended deceased from March 4, 1923, to April 5, 1923,

that I last saw her alive on April 5, 1923

and that death occurred, on the date stated above, at 3:50 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency,

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Nephritis,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Schumich M. D.

(Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL April 7 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S NAME should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74544

CERTIFICATE OF DEATH.

31 D74544

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3218 Foster Ave ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine J. Hoffinger

(a) RESIDENCE NO. 3218 Foster Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) June 11 - 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John G. Hoffinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Hein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Catherine Hoffinger 3218 Foster Ave

15 APR 6-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1922, to April 4, 1923, that I last saw he alive on April 1, 1923, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH was as follows: *

Phthisis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Gastritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Beacom M. D.

4/4, 1923 (Address) 2201 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL April 7 1923.

20 UNDERTAKER Lilly and Zeller

ADDRESS 403 S. Monroe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. AGE mation should be carefully supplied. so that it may CAUSE OF DEATH in plain terms, may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74545

CERTIFICATE OF DEATH.

33 D74545

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Lee

(a) RESIDENCE NO. 51 N. Carolina St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS RECORD IS PERMANENT. mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records. (Address)

15 APR 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to April 3, 1923, that I last saw h er alive on April 3, 1923, and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

4-4-23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury

DATE OF BURIAL April 7 1923

20 UNDERTAKER John W Henderson

ADDRESS 1601 E mament

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74546

CERTIFICATE OF DEATH.

S 6623

90 D74546

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 E. Fort ave. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise E. Potter

(a) RESIDENCE. No. 602 E. Fort ave. St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Potter

6 DATE OF BIRTH (month, day, and year): Aug 8, 1867

7 AGE — Years: 55 — Months: 7 — Days: 26 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cumberland Md.

PARENTS

10 NAME OF FATHER: Jacob Fuchs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Chas. Potter 602 E. Fat ave.

15

APR 6-1923 ROBERT R. KRAUTER (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to April 4, 1923, that I last saw h[illegible] alive on April 6, 1923, and that death occurred, on the date stated above, at 1:12 m.

The CAUSE OF DEATH* was as follows:

Uremia (Nephritis)

Contributory (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland, Md. — DATE OF BURIAL: 4/6 1923

20 UNDERTAKER: E. J. Fanning — ADDRESS: Dec 1660 Battery Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Fill in all blanks. Information supplied. AGE should be stated EXACTLY. If less than one day, the CAUSE OF DEATH should be carefully stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74547

HEALTH DEPARTMENT—CITY OF BALTIMORE

63

D74547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 N. Aisquith St.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Lee Guy

(a) RESIDENCE. No. 1507 N. Aisquith St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 20/1902

7 AGE: Years 20 | Months 3 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: James R. Guy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va.

12 MAIDEN NAME OF MOTHER: Nellie E. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): National Soldiers Home Va.

14 Informant (Address): James R. Guy 1507 N. Aisquith St.

15 Filed APR 6-1923 ROBERT H. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from August 6 1922, to April 4 1923, that I last saw her alive on April 1-4 1923, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Addisons Disease

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 1 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Faudree M. D.

. 19 (Address) 15 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem. DATE OF BURIAL: Apr. 7 1923

20 UNDERTAKER: Wm. C. Black ADDRESS: 927 N. Broadway

Spec.—1-10-21—M&T—1500 Blks.

D74548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74548

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L Munro

(a) RESIDENCE No. Titusville, Pa. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel J. Munro

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER William Munro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER ,, ,,

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant JOHNS HOPKINS HOSPITAL.

(Address) ROBERT R. KRAUTER.

Filed APR 6-1923. 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1923. to April 6, 1923. that I last saw h[illegible] alive on April 6, 1923, and that death occurred, on the date stated above, at 12-40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon with gastro-Colic Fistula

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Titusville Pa.

Did an operation precede death? Yes Date of March 31 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. of tissue

(Signed) Warfield M. Cole M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Suncor Ont Canada

DATE OF BURIAL Apl 6 1923.

20 UNDERTAKER John Mitchell

ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should have information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D74549

D74549

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 E Clement ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Edward Clark

(a) RESIDENCE. NO. 511 E Clement ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
BUSHAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur do

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William J. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Margaret Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md

14 Informant (Address) Mr Edw. Clark. 511 E Clement St

15 Filed APR 6 1923 . 19 . ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 . 1923 . to April 3 . 1923 .

that I last saw h alive on April 3 . 1923 .

and that death occurred on the date stated above, at 1.15P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J Prioleau M. D.

4/4 . 1923 (Address) 1279 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 6 1923
20 UNDERTAKER Margaret L. Flynn	ADDRESS 1922 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74550

CERTIFICATE OF DEATH.

161-001

D74550

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Isidge Hall

(a) RESIDENCE NO. University Hospital ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6, 1923

7 AGE — Years — Months — Days — If LESS than 1 day, 1 hrs or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Cobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Marjorie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Boston Virginia

14 Informant ....

(Address) ....

15 APR 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to April 6, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(30 wks)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood Wilson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19 APR 6 1923

20 UNDERTAKER: Commissioner Health.

ADDRESS

Par. Wm. H. WOODALL

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74551

CERTIFICATE OF DEATH.

162 D74551

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary 6 WARD)

CITY OF BALTIMORE: (NO. ..... ST., ...

2-FULL NAME Baby boy Jones —

(a) RESIDENCE NO. None ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	✓

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Apr 4.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. ..... min.
Child lived 1 hr after birth			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 0 0

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Church Home & Inf.

PARENTS

10 NAME OF FATHER Charles L. Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Edmina McKinney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant ~~Mother~~ Mrs Edmina Jones

(Address) 1012 [illegible]

15 APR 6-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1923

17 I HEREBY CERTIFY, That I attended deceased from April 4 to 19

that I last saw him alive on Apr 4, 1923,

and that death occurred, on the date stated above, at 530 P m.

The CAUSE OF DEATH* was as follows:

Asphyxiation, failed

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) ✓

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? yes —

What test confirmed diagnosis? ✓

(Signed) H. C. Rice — M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner of Health,

Per. Wm. E. WOODALL

APR 6-1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

112

Spec.—1-10-21—M&T—1500 Blks.

D74552

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D74552

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 Smith ST., 16 WARD)

2-FULL NAME Susie Southern

(a) RESIDENCE NO. 1324 Smith ST., WARD

(Usual place of abode) dont

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	widow

5a If married, widowed, or divorced (or) WIFE of Wesley Southern

6 DATE OF BIRTH (month, day, and year) — — 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
59				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Branch

(c) Name of employer Forest Park

9 BIRTHPLACE (city or town) New Market (State or country) Md.

PARENTS

10 NAME OF FATHER Hamilton Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) —

14 Informant Morgan Johnson (Address) 1324 Smith St

15 Filed APR 6 1923, 19 Robert F. Harrison, Burial Permit Clerk. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS' ... mation should be carefully supplied. AGE ... should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 2, 1923, to Apr. 4 — 1923, that I last saw her alive on Apr. 4 — 1923, and that death occurred, on the date stated above, at 2-45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of — —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. L. McCarthy M. D.

19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr 8 1923

20 UNDERTAKER John H. Toadvine ADDRESS 142 W Hill St

Spec.—1-10-21—M&T—1500 Bks.

D74553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74553

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 W Barre ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Armenta Cox

(a) RESIDENCE No. 602 W Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jas E. Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jannia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant

(Address) 602 W Barre St

15 APR 6 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1923.

17

I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1922. to April 3, 1923.

that I last saw her alive on April 3, 1923.

and that death occurred, on the date stated above, at 4-15a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis (Chronic)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

19 (Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr 8 1923
20 UNDERTAKER John N. Treadwell	ADDRESS 1122 Ashland Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74554

CERTIFICATE OF DEATH.

4 4 D74554

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Union Ave. ST., 13 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Price

(a) RESIDENCE No. 1212 Union Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. x mos. x ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Price

6 DATE OF BIRTH (month, day, and year) Aug. 12/1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	70	7.	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Retired

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto city Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Effie Lockner 1112 Union ave.

15 APR 6-1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/ 1923

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to April 5, 1923, that I last saw h[illegible] alive on April 5, 1923, and that death occurred, on the date stated above, at 2.30A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas A Schaefer, M. D.

, 19 (Address) 53 E. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery	4/7/ 1923
20 UNDERTAKER Walter Davis	ADDRESS 330 Paine St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74555 D74555

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 St Paul St ST.: 11 WARD)

2-FULL NAME John B. Roberts

(a) RESIDENCE. No. 1116 St Paul St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary M. Roberts

6 DATE OF BIRTH (month, day, and year) Aug. 4th 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Va
(State or country)

PARENTS

10 NAME OF FATHER Thos H. Roberts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Margaret Hudson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mrs. Francis A. White
(Address) Baltimore Md

15 Filed Robert P. Harrison, Registrar

APR 6-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 1914, to Apr. 6th, 1923, that I last saw h[illegible] alive on Apr. 5th, 1923, and that death occurred, on the date stated above, at 1 40 A.m.

The CAUSE OF DEATH* was as follows:

acute nephritis,

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary.

(Signed) Wm M. Dabney, M. D.

(Address) Reisterstown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 7, 1923
20 UNDERTAKER	ADDRESS
P. Gilmusetos & Co	Eutaw & Mc Culloh

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. See instructions on back of certificates

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis

D74556 HEALTH DEPARTMENT—CITY OF BALTIMORE D74556

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH 10 W Madison St

CITY OF BALTIMORE (No. 918 Madison Ave St. 11 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Tazewell Redwood

(Residence in Baltimore: No. 918 Madison Ave St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. PENCIL SHOULD NOT BE USED.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December (Month) 27 (Day) 1904 (Year)

7-AGE, 18 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Francis T. Redwood

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER Mary B. Coale

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr John Redwood

(Address) Ruxton Md

15- April 6, 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot by pistol shot wound in brain, while probably suffering with temporary mental aberration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Riley M. D.

(Coroner) April 6, 1923 (Address) 1059 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	April 7, 1923
20-UNDERTAKER Henry Hankins & Son	ADDRESS Orchard nr Collord St

Spec.—6-S-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74557 ✓

D74557

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1233 McElderry ST.: 5 WARD)

2-FULL NAME Mildred Stanley

(a) RESIDENCE. NO. 1233 McElderry ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2 Dec. 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inf.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Ceef White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rosa Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co Md

14 Informant (Address) Rosa Stanley 1233 McElderry St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 Apl. 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-Mar. 1923 to ✓ Apl. 1923 that I last saw her alive on ✓ 4 Apl. 1923 and that death occurred, on the date stated above, at 2 ✓ 00 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac arrhythmia

Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam.

(Signed) Jonas Friedenwald M. D.

6/4/1923 (Address) 1211 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cem.

DATE OF BURIAL April 8 1923

20 UNDERTAKER Wm. J. Locks

ADDRESS 1322 Hanover

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74558 HEALTH DEPARTMENT—CITY OF BALTIMORE D74558

CERTIFICATE OF DEATH.

100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 Hamstead Ct. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Griffin

(Residence in Baltimore: No. 17 Hamstead Ct. St.; 50 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. OCCUPATION should be stated EXACTLY. PHYSICIANS should

NOTICE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: black

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: unknown ..... 1..... (Month) (Day) (Year)

7-AGE: about 50 yrs ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Leonard Griffin

11-BIRTHPLACE OF FATHER, (State or Country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER, (State or Country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Brown (niece)

(Address) 4 N. Spring St.

15- Filed 192

Robert P. Harrison, Burial Permit Clerk Registrar.

APR 6 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~March~~ April 5/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hall M. D.
(Coroner.)

4/5/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Laurel Cem. DATE OF BURIAL: 4/7 1923

20-UNDERTAKER: Jas. M. Shipley ADDRESS: 2 Mad. st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74559

CERTIFICATE OF DEATH.

3/ D74559

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Zacks

(a) RESIDENCE No. 2820 Frederick ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Zacks

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Byer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address) M.T.H.

15 APR 6 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1923

17

I HEREBY CERTIFY, That I attended deceased from February 6, 1923, to April 5, 1923,

that I last saw her alive on April 5, 1923,

and that death occurred, on the date stated above, at 6.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dadaplicca M. D.

4-6-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apl. 9 1923
20 UNDERTAKER	ADDRESS
George L. Sohmar & Co.	Edmondson Ave.

MARYLAND RECORD OFFICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74560

CERTIFICATE OF DEATH.

10

D74560

REGISTERED NO.

1-PLACE OF DEATH St Vincents Orphan Asy.

CITY OF BALTIMORE: (No. 1701 division St ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Waters

(a) RESIDENCE No. 2223 Mc Henry St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. EVERY ITEM should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Wht.

5 Single, Married, Widowed, or Divorced. (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	2	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Waters.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Helen Kaufman Engerstorska

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Helen Walters (Address) 2223 Mc Henry St.

15 APR 6-1923 Robert P. Harrison, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1923, to April 6, 1923, that I last saw h[illegible] alive on April 6, 1923 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria Intox.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. R. Goldborough M. D.

19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr. 7 1923
20 UNDERTAKER	ADDRESS
George Lehmann	201 Cathedral

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74561 ✓ D74561

D74561

CERTIFICATE OF DEATH.

REGISTERED NO. C 9 129

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1304 Valley ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Teresa Curran

(Residence in Baltimore: No. 1304 Valley Street St.; ..... yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7-AGE, 17 yrs. 1 mos. 11 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: school girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md. U.S.A

PARENTS.

10-NAME OF FATHER. Edw. M. Curran

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Nellie Kenny

13-BIRTHPLACE OF MOTHER (State or Country). N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nellie Curran

(Address) 1304 Valley St.

15-

Filed ..... Robert P. Harrison, ... Registrar.

APR 6-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1922, to April 4 1923, that I saw h[er] alive on April 4 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Melena Neonatorum 3 hours

(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Che. Pancreatic stones

Nephritis (Duration) ..... yrs. 11 mos. ..... da.

(Signed) William A. Frank M. D.

April 6, 1923 (Address) 202 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Apr. 7, 1923

20-UNDERTAKER J. C. Waddell d 914 — ADDRESS Gruman Ave

WRITE PLAINLY, WITH UNFADING INK.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Glaspy)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74562

CERTIFICATE OF DEATH.

D74562

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2410 McElderry St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Glaspy

(a) Residence No. 2410 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Charles Glaspy

6-DATE OF BIRTH (month, day and year): Dec 9 1860

7-AGE: 63 yrs. 3 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: William Fulch

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Christopher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14-

(Informant): Emma Glaspy

(Address) 2410 McElderry St

15-

Filed 6-1923

Robert P. Harrison, M.D.

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4-4-23

17- I HEREBY CERTIFY, That I attended deceased from 4-1 1923 to 4-4 1923

that I last saw h[illegible] alive on 4-4 1923

and that death occurred, on the date stated above, at 6 30 M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. mos.

CONTRIBUTORY (Secondary): acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Intirmary

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fingering

(Signed) [illegible] M.D.

(Address) 6 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 7 1923
20-UNDERTAKER	ADDRESS
Geo C Miller	2534 Jefferson St

Should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74563

CERTIFICATE OF DEATH.

D74563

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3030 Belmont Ave WARD)

2-FULL NAME Ida L. Hoedinger

(a) RESIDENCE No. 3030 Belmont Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas. Wm. H. Hoedinger

6 DATE OF BIRTH (month, day, and year) Oct 15 1856

7 AGE: Years 66 Months 5 Days 21 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Gottleib Kanell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Nellie Klages
(Address) 3030 Belmont Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

APR 6 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1923, to April 5, 1923.

that I last saw h[illegible] alive on April 5, 1923

and that death occurred, on the date stated above, at 7.40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary sclerosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo W Hymmet M. D.

4-6, 1923 (Address) 3002 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. — DATE OF BURIAL: Apr 9 1923

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 2078 E. Pr.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74564

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2825 Rayner Ave. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Dr. Walter Griffin Hammond

(a) Residence No. 2825 Rayner Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Bertie Primrose Hammond

6-DATE OF BIRTH (month, day and year) Oct. 10-1865

7-AGE, 57 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work... Poultry dealer
(b) General nature of industry, business, or establishment in which employed (or employer)...
(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Nathan A. Hammond

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Cecelia Griffin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Walter G. Hammond
(Address) 1825 E. Monument st

15- Filed 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 5-1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 5, 1923, to Apr 5, 1923, that I last saw him alive on Apr 4, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chr. interstitial nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Homer C. Todd M. D.

4/5, 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL, April 7, 1923

20-UNDERTAKER, W. M. Cooke — ADDRESS 502 E North Ave

R 6-1923

should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Directions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74565

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1823 Lemmon St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Robert Fulton Young

(a) Residence No. 1823 Lemmon St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 28, 1922

7-AGE, 1 yrs. 2 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Robert F Young

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Wvalton Md.

12-MAIDEN NAME OF MOTHER, Laura L Chrisastle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Robert F Young

(Address) 1823 Lemmon St

15- Filed, 19.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 5, 23

17- I HEREBY CERTIFY, That I attended deceased from Apr 4, 1923, to Apr 5, 1923

that I last saw h.....alive on Apr 4, 1923

and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY Measles

(Secondary)

(Duration) ...yrs. ...mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James L Clayton, M. D.

4/6, 1923 (Address) 1729 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loraine Cemetery

DATE OF BURIAL, April 7, 1923

20-UNDERTAKER, Wm Cook

ADDRESS 502 E North Ave

NOTE—WHITE PAPER FOR WHITE. COLORED FOR COLORED. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

6-1923

Gilmor 5237

Spec.—1-10-21—M&T—1500 Bks.

D74566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74566

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 77 WARD)

2-FULL NAME Wm. H. Beasley

(a) RESIDENCE NO. Orkney Road, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary S. Beasley

6 DATE OF BIRTH (month, day, and year) Feb. 10th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Investor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Plymouth
(State or country) N. C.

PARENTS

10 NAME OF FATHER John B. Beasley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Alexander

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant William F. Beasley Jr.
(Address) 3033 Windsor Ave.

15 6-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 4.1. 1923, to 4.6. 1923,

that I last saw h[illegible] alive on 4-6- 1923,

and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Valvular insufficiency

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Chronic Tonsilitis Congestion

2 Days (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Newton S. Carr, M. D.

4/6. 1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
R. Johns Cem York Rd.	Apr. 7 1923
20 UNDERTAKER	ADDRESS
Joseph L. Cook	1003 W. Balto St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-4-001

D74567

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 W. Mulberry St. ST., 19 WARD)

2-FULL NAME Jane M. Sapp

(a) RESIDENCE NO. 1408 W. Mulberry St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Sapp

6 DATE OF BIRTH (month, day, and year) Feb. 2" 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hoggstown
(State or country) Pa.

PARENTS

10 NAME OF FATHER Nathaniel Eckels

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Firvoed

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Eugene H. Sapp
(Address) 1408 W. Mulberry St.

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

APR 6 -1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4" 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to April 4, 1923, that I last saw her alive on April 4, 1923, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy. Paralysis

about (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos. Delany Thomas, M. D.

4/4, 1923 (Address) 612-613 Professional Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr. 7 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74568

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74568

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 S. Greene St ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nanny Morgenthal

(a) RESIDENCE NO. 30 S. Greene ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Louis Morgenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fanny Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rebecca Attenheimer (Address) Owens Apts

15 Filed 4-7-1923 Robert D. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5 1923 to April 6 1923, that I last saw h alive on April 6 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Gastroenteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Shadowsky M. D.

4/6 1923 (Address) 638 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cemetery

DATE OF BURIAL 4/7 1923

20 UNDERTAKER J. Ahern & Co

ADDRESS 1611 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

Spec.—1-10-21—M&T—1500 Bks.

D74569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74569

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Highland Ave. WARD 26)

2-FULL NAME Winifred J. Witney

(a) RESIDENCE NO. 108 N. Highland Ave. WARD 26

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov. 27. 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Schoolchild

(c) Name of employer none

9 BIRTHPLACE (city or town) Elizabeth (State or country) New Jersey

PARENTS

10 NAME OF FATHER Clarence Witney

11 BIRTHPLACE OF FATHER (city or town) Chicopee (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Helen Tettemer

13 BIRTHPLACE OF MOTHER (city or town) Phila. (State or country) Pennsylvania

14 Informant Clarence Witney (Address) 108 N. Highland Ave

15 Robert V. Harrison, Registrar

APR 7 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to April 6, 1923,

that I last saw h[illegible] alive on April 5, 1923,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia following pleural abscess

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Scarlet fever

(duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? Doctor(?)

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/6, 1923 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL April 7 1923

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74570 HEALTH DEPARTMENT—CITY OF BALTIMORE D74570

CERTIFICATE OF DEATH. 6 162 Registered No. C.....

1-PLACE OF DEATH Johns Hopkins Hospital

City of BALTIMORE: (No. 7 N. Wolfe St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Boy) Plumhoff

(Residence in Baltimore: No. 7 N. Wolfe St.; yrs. 1/1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Single

6-DATE OF BIRTH. Mar 31/23 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
.....yrs. .....mos. 5 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER. Wilbur Plumhoff

11-BIRTHPLACE OF FATHER. (State or Country). 7 N. Wolfe St. MD.

12-MAIDEN NAME OF MOTHER. Delia Myers

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilbur Plumhoff

(Address) 7 N. Wolfe St.

15- Robert P. Harrison,

APR 7-1923 192 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April TWE/ 5/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage in occipital region of brain. Also in both kidneys
(Autopsy at hospital)
(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Delayed birth- cyanosed at birth. (Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. H. Culver M. D.
(Coroner.)
4/6 192 3 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem.	April 7 1923
20-UNDERTAKER.	ADDRESS
A. Sauder Sons	1710 Pearl St.

—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74571

CERTIFICATE OF DEATH.

13 47

D74571

1-PLACE OF DEATH Homewood Hosp. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2724 N. Charles St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Estelle Smith

(Residence in Baltimore: No. 3007 Pennsylvania Ave St.; Less than 1 yrs. mos. ds.)

WHITE REGISTRATION. A.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHRASES such as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, June (Month) 6th (Day), 1874 (Year)

7-AGE, 48 yrs. 10 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Daniel Cline.

11-BIRTHPLACE OF FATHER (State or Country), Rockingham Co. Va.

12-MAIDEN NAME OF MOTHER Martha Jane Mc Afee.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George M. Smith

(Address) 3007 Penna. Ave.

15-

Filed APR 7 1923 Robert P. Harrison. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 6 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1st 1922, to March 6th 1923, that I saw her alive on March 5th 1923, and that death occurred, on the date stated above, at 10.55 P.m.

The CAUSE OF DEATH* was as follows:

(Septicaemia.)
Edema. Carcinoma of Lungs.
Breast.

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Edema. Carcinoma.

(Duration) 1 yrs. 1 mos. ....ds.

(Signed) Wm Conrad Bode, M. D.

April 6, 1923 (Address) 1900 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL Apr. 9th, 1923

20-UNDERTAKER Joseph P. Cox ADDRESS 1003 N. Gilts St

Spec.—1-10-21—M&T—1500 Bks.

D74572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74572

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Simmons.

(a) RESIDENCE NO. 724 W. 34th St. Balt. Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Simmons

6 DATE OF BIRTH (month, day, and year) Apl 25-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56 yrs.	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Mark Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Benjamin Simmons (Address) 2147 W 33rd St

15 Robert P. Harrison, Registrar
APR 7 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6th 1923

17

I HEREBY CERTIFY, That I attended deceased from Mch 16th, 1923, to April 6th, 1923, that I last saw her alive on April 6th, 1923, and that death occurred, on the date stated above, at 12 1/2 a.m.

The CAUSE OF DEATH* was as follows:

myocanditis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of ovary.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 4, 1923

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edward H. Kitlowski, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Apl 9 1923
20 UNDERTAKER	ADDRESS
Ehenowith Son	Chestnut Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS ... mation should be carefully supplied. AGE should b... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ... ...ld be stated EXACTLY. PHYSICIAN ... ...y be properly classified. Exact statement of OCCUPA... ...k of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74573

CERTIFICATE OF DEATH.

D74573

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 N. Dallas ST., 8 WARD)

2-FULL NAME Claude William Trogdon

(a) RESIDENCE No. 1524 N. Dallas ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child of Gertrude Trogdon

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ....min.
14	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C Lived in Balt 11 years

PARENTS

10 NAME OF FATHER Joe Trogdon

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Girtrude Pool

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Girtrude Trogdon (Address) 1524 N Dallas ST

15 Robert P. Harrison, Registrar

APR 7 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 28. 1923. to April 6. 1923.

that I last saw him alive on April 5. 1923

and that death occurred, on the date stated above, at 12.55 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 7 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr C W Kennard, M. D.

4-6 1923 (Address) 708 Custer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL April 8 1923

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1726 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74574

CERTIFICATE OF DEATH. 74-001

D74574

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Jancy

(a) RESIDENCE NO. 519 W. Barre St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records.

(Address)

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to April 4, 1923, that I last saw her alive on April 4, 1923, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

4-7-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 7-1923

APR 7-1923

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK. This certificate must be filled out in full. All questions should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of RESIDENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74575

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74575

CERTIFICATE OF DEATH.

11

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Thomas

(a) RESIDENCE No. 1203 Park ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER James Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records

(Address) M.G.H.

15 Filed APR 7-1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 2, 1923, that I last saw him alive on April 2, 1923, and that death occurred, on the date stated above, at 12.40 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. Unknown mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances L. Dadoplicella M. D.

4-3-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 7-1923

UNIVERSITY OF MARYLAND.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSES is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74576

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 N. Caroline ST., 8 WARD)

2-FULL NAME Mary Millar

(a) RESIDENCE NO. 1313 N. Caroline ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Millar Jr.

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Early

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Rachel ----

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant J. Howard Millar
(Address) 1313 N. Caroline St.

15 Filed Apr 7 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1923, to Apr 5, 1923, that I last saw h.. alive on Apr 5, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chronic Endocarditis.

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) ... yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) J. Wallace Harrison M. D.

Apr. 7, 1923 (Address) 1328 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	4/7 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS' information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Burial Permit Clerk

Spec. 1-10-21—M&T—1500 Blks.

D74577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D74577

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 E. Monument ST., 7 WARD)

2-FULL NAME J. George Hesse

(a) RESIDENCE NO. 1919 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May — 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: City

(b) General nature of industry, business, or establishment in which employed (or employer): Condemnation

(c) Name of employer: Examiner

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: George Hesse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sophie Schuh

(Address) 500 N. Pat. Pk ave

15 Filed APR 7 - 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Apr 4, 1923.

that I last saw him alive on Apr 3, 1923

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of brain and bowels

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Removal of cancer from neck

(Signed) I was asso. Robert Woods, M. D.

, 19 (Address) 2530 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL 4/7 1923

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Odena

B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74578

CERTIFICATE OF DEATH.

10 D74578

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 N. Castle ST., 6 WARD)

2-FULL NAME Howard H. Ernst

(a) RESIDENCE NO. 12 N. Castle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11-22

7 AGE — Years | Months 9 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Harry Ernst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. Schammel

12 MAIDEN NAME OF MOTHER Gertrude E.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry Ernst (Address) 12 N. Castle St.

15 Filed APR 7 1923 .19.. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to April 6, 1923, that I last saw him alive on April 6, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H F Herzog M.D., M. D.

April, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. | DATE OF BURIAL 4/9 1923

20 UNDERTAKER Philip Herwig | ADDRESS 2016 Wilkens

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS shall be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Virulence test
Culture positive for
Diphtheria. Positive

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74579

CERTIFICATE OF DEATH.

100-001

D74579

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital, St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wiley

(a) Residence No. 1715 Etting St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1869

7-AGE.	If LESS than 1 day.
53 yrs. mos. ds.	hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Cooper

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Eastern Shore, Md.

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Eastern Shore, Md.

14- (Informant) Municipal Hospital Records

(Address)

15- APR 7-1923 Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 4, 1923

17- I HEREBY CERTIFY, That I attended deceased from December 9 19 18 to April 4 19 23

that I last saw her alive on April 3 19 23

and that death occurred, on the date stated above, at 6:40 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James A. Dennis M. D.

4-4-, 1923 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Locust	April 7, 1923

20-UNDERTAKER, James A. Dennis ADDRESS 130 S Fremont Ave

Burial Permit Clerk.

N. B.—WRITE PLAINLY. Information must be supplied EXACTLY. PROFESSIONAL TERMS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Cause of death must be certified. Exact statement of OCCUPATION is very important. Cause of death must be certified. Please see instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 161-001

D74580

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Cumberland ST., 15 WARD)

2-FULL NAME Clara E. Braden

(a) RESIDENCE No. 703 Cumberland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 23 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 703 Cumb. St

PARENTS

10 NAME OF FATHER Chas Braden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Dorothy Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Chas. Braden

(Address) 703 Cumb St

15 Filed ....., 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 7 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6th 1923

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1923, to Apr. 6, 1923,

that I last saw h[illegible] alive on Apr. 5, 1923

and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 months)

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) Weakness & Lack of Nourishment

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 1005 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral.

DATE OF BURIAL 4/7/23, 19

20 UNDERTAKER Martin Bahey & Sons.

ADDRESS 1827 N North Ave

A. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74581 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

11-001 D74581

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1710½ E Monument St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Martha J Myers

(a) Residence No. 1710½ E Monument St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 15-1855

7-AGE. 68 yrs. 9 mos. 10 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. seamstress

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Jacob Myers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER. Martha Freborne

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

11- (Informant) Mrs. Barbara Johnson

(Address) 1710½ E Monument St

15- Filed ..... 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk

APR 7 - 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-5-23

17- I HEREBY CERTIFY, That I attended deceased from 4-1 1923 to 4-5 1923

that I last saw her alive on 4-5 1923

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

grippe

(Duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) F Fritz Ruzicka M.D.

4-7, 1923 (Address) 500 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Hill Cem	April 9, 1923
20-UNDERTAKER. Wm C Muller	ADDRESS 2354 Jefferson St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74582 HEALTH DEPARTMENT—CITY OF BALTIMORE D74582

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1814 N. Duncan St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant A. G. August & Agnes Bitter

(a) Residence No. 1814 N. Duncan St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 6-1923

7-AGE. — yrs. — mos. — ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, August Bitter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Agnes Campbell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Wilmington Del.

14- (Informant) August Bitter

(Address) 1814 N. Duncan St.

15- Filed APR 7 1923 [illegible] Harrison, Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 6-1923

17- I HEREBY CERTIFY, That I attended deceased from April 6 1923 to April 6 1923 that I last saw her alive on April 6 1923 and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature (2 months fetus)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D

4/7, 1923. (Address) 1206 E. Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Apr. 7, 1923

20-UNDERTAKER: Mrs C. Miller ADDRESS: 2334 Jefferson

should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74583

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 122 W. Hamburg St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Lezette.

(Residence in Baltimore: No. 122 W. Hamburg St. St.; 2 yrs., 1 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single

6-DATE OF BIRTH, February 7th. 1921., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
2 yrs. 1 mos. 29 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Collins C. Lezette.

11-BIRTHPLACE OF FATHER, (State or Country). New York.

12-MAIDEN NAME OF MOTHER, Mary L. Tudor.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Lezette. (mother)

(Address) 122 W. Hamburg St.

15-

Filed ..... 19.. Robert P. Harrison, Registrar.

1923 Part 1 Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5th. 1923., 19.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental scalds about the face and body by upsetting of a pot of coffee.

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Apl. 6th 1923 (Address) 1017 E. Charles St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	April 7. 1923
20-UNDERTAKER,	ADDRESS
John F. Denny	715 Light St

N. B.—Every item of information should be answered, so that it may be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74584

CERTIFICATE OF DEATH.

129 D74584

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Pennington Ave. Curtis Bay 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Herman Trimpe

(a) RESIDENCE NO. 729 Pennington Ave. Curtis Bay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia C. Trimpe

6 DATE OF BIRTH (month, day, and year) May 11 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Boilermaker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Trimpe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Klosterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia C. Trimpe

(Address) 729 Pennington Ave.

15 Robert F. Harrison, 19

Burial Permit Clerk. Registrar

APR 7-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 16 1923, to Apr. 5 1923, that I last saw him alive on Apr. 4 1923, and that death occurred, on the date stated above, at 9 x 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. Urine.

(Signed) William A. Leath, M. D.

Apr. 1923 (Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL April 9 23

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

B.—WRITE PLAINLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. EXACT mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74585

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 E. Park Ave., Raspeburg St., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Malkus.

(a) RESIDENCE NO. 20 E. Park ave. Raspeburg ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernst Malkus.

6 DATE OF BIRTH (month, day, and year): Sept. 8, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Kleilein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Eber.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Ernst Malkus

(Address) 20 E. Park Ave. Raspeburg Md

15 Filed 7-1928, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1923

17 I HEREBY CERTIFY, That I attended deceased from at death, 19 to 19

that I last saw her alive on April 5 1923

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

30 minutes (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no. Ordered by Coroner 4/7/23

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

, 19 (Address) Raspeburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: April 8 1923

20 UNDERTAKER: Fred Lescalette Sons — ADDRESS: Fullerton

N.B.—WHITE PAPER. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74586

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74586

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1738 Sargent St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma G. Turner

(Residence in Baltimore: No. 1738 Sargent St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Nov 12 1922 (Month) (Day) (Year)

7-AGE. yrs. 4 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balt City

PARENTS:
10-NAME OF FATHER, Edward Turner
11-BIRTHPLACE OF FATHER, (State or Country): Balt City
12-MAIDEN NAME OF MOTHER, Margaret Nurbauer
13-BIRTHPLACE OF MOTHER, (State or Country): Westmoreland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Turner

(Address) 1731 Sargent St

15- Apr 7 1923

Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisty (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisty (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis following Pneumonia

(Duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Fenton M. D. (Coroner.)

April 5 1923 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Mt Olivet Cemetery April 7 1923

20-UNDERTAKER. ADDRESS

Harry N. Witz Co 1131 Lombard St

No. 7—Every item of information should be given as accurately as possible, so that it may be properly classified. Exact statement of occupation and cause of death is very important. See instructions on back of certificate.

Spec. 1-10-21 MA 1 1500 Blks.

D74587

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74587

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH University Hospital 27

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Hunicatt

(a) RESIDENCE No. 220 Biloxi Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 17, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	3	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Ben Hunicatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nellie Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Father

(Address) 220 Belvidere Ave

Filed APR 7 1923 Robert P. Harrison, M. D. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/16, 1923, to 4/5/23, 19...,

that I last saw h[illegible] alive on 4/5/23, 19...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

3 weeks (duration) ..... yrs. mos. four ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W C B Jones M. D.

4/6, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Ridge Cemetery	April 9 1923

20 UNDERTAKER Harry F. Hughes ADDRESS 1531 W Fayette St

NOTICE—This certificate should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PLACE OF DEATH is very important. See instructions on back of certificates.

D74588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74588

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hosp ST.: 7 WARD)

REGISTERED No. C 457

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James T. Hurst

(Residence ~~in Baltimore No.~~ Johns Hopkins Hospital Parksley Va St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 6, 1896 (Month) (Day) (Year)

7-AGE 26 yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER. Chas L. Hurst

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Minnie Dunn

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl Hurst

(Address) Parksley, Va

15- Filed APR 8 - 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Duration) 2 yrs. mos. ds.

(Signed) G. S. Y. Colter M. D. (Coroner.)

4/7/23 (Address) 5 S. E. Court Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Parksley Va

19-PLACE OF BURIAL OR REMOVAL, Parksley Virginia

DATE OF BURIAL, 4/7, 1923

20-UNDERTAKER Chas A Evans & Son

ADDRESS 118 W Mt Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-23-21—E.B.P.S.—400 Bks.

D74589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74589

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John E. Jeffers.

(a) Residence No..... Home for the aged, City St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) Dec. 21836

7-AGE, 86 yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Thos. H. Jeffers

11-BIRTHPLACE OF FATHER (city or town)..... Balto.
(State or Country). Md.

12-MAIDEN NAME OF MOTHER, Mary Hooper

13-BIRTHPLACE OF MOTHER (city or town)..... Balto.
(State or Country). Md.

14-(Informant)..... Frank H. Jeffers

(Address) 1527 Edmondson Ave.

15-FILED APR 8 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 8 '23

17- I HEREBY CERTIFY, That I attended deceased from March 31 1923 to April 8 1923, that I last saw h.. alive on April 7 1923, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 4, ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed)..... D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	4/10/23
20-UNDERTAKER.	ADDRESS
Wm J Smith 1542	Baltimore

Should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74590

D74590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE (No. Municipal Hospital. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Owings

(a) Residence No. 147 N. Front St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1854

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Horseshoer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Somerset Co., Md.

PARENTS.

10-NAME OF FATHER, Philip Owings

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Somerset Co., Md.

12-MAIDEN NAME OF MOTHER, Levenia D. Parks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Somerset Co., Md.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed APR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 2 1923 to April 7 1923

that I last saw him alive on April 6 1923

and that death occurred, on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

4-7- 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Apr 10, 1923
20-UNDERTAKER, George E. Smith	ADDRESS 1532 Hollins st

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74591

D74591

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Home of the Aged St. or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Morrow

(a) Residence No. N. B.A. Fulton and Franklin St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
F	W	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 30 1848

7-AGE. 74 yrs. 8 mos. 6 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto Co Md

PARENTS.

10-NAME OF FATHER, John Morrow

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Co.

12-MAIDEN NAME OF MOTHER, Rebecca Wright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Co

14-(Informant) Rosetta Cuddy

(Address) Home Aged

15-Filed APR 8 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr-6-1923

17- I HEREBY CERTIFY, That I attended deceased from Apr-6- 1923 to ..... 19..... that I last saw him alive on Apr 6 1923 and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

from history (Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole M. D

4/7/23 19 (Address) 2702 Garrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Pleasant Hill	Apr 8 1923
20-UNDERTAKER, George J. Smith	ADDRESS 1532 Hollins St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74592

CERTIFICATE OF DEATH.

D74592

1-PLACE OF DEATH 4001 Springdale

City of BALTIMORE: (No. ..... St., 15 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norah Jones

(a) Residence No. 4001 Springdale St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 7 1847

7-AGE, 75 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Public School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 68

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Frenchtown Md.

PARENTS.

10-NAME OF FATHER Robert L. D. Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Harriett Palmer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Estelle Reed

(Address) 4001 Springdale Ave

15- Filed APR 8 1923 192 ROBERT R. KRAMER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 7 1923

17- I HEREBY CERTIFY, That I attended deceased from March 20 1923 to April 7 1923

that I last saw h— alive on April 6 1923

and that death occurred, on the date stated above, at 6.20 A. M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 17 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. A. Hibbs, M. D.

April 7, 1923 (Address) 2220 Garrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Dead Ridge Cemetery	April 10, 1923
20-UNDERTAKER. George J. Smith	ADDRESS 1653 Hollins Ave

should be carefully supplied. Age always to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Samuel H. Scoggins Walker-1-Center

D74593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74593

CERTIFICATE OF DEATH.

X 49

1-PLACE OF DEATH City of BALTIMORE (No. Southern Hospital 12 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel H. Scoggins

(a) Residence No. Morehead City N.C. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 wks How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

If married, widowed, or divorced, HUSBAND of (or) WIFE of Ella C. Scoggins

6-DATE OF BIRTH (month, day and year) Oct 25, 1859

7-AGE, 63 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) ..... J. E. Woodland

(c) Name of employer ..... North Carolina

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER Samuel R. Scoggins

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Mary J. Askey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14- (Informant) John J. Scoggins

(Address) 1203 East North Ave

15- Filed APR 8-1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 6-23

17- I HEREBY CERTIFY, That I attended deceased from Mar 15 1923 to Apr 4 1923, that I last saw him alive on Apr 4 1923, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Prostate

About (Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

, 19 (Address) 1 E Center St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. April 9 1923

20-UNDERTAKER. William Cook — ADDRESS 502 E. North

Exact statement of OCCUPATION is very important and should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74594

124

D74594

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eldora Payne

(a) RESIDENCE NO. 1951 N. Patt Pk. Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C Payne

6 DATE OF BIRTH (month, day, and year) April 13 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
53	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Henry Manns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eve. Mc Cloe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Charles C. Payne (Address) 1951 N. Patterson Park

15 Filed APR 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1923, to April 6, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart
Pulmonary Edema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Cholecystitis
& Lithiasis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of 4-4-23

Was there an autopsy? no

What test confirmed diagnosis? Operation P. G. & S.

(Signed) J. V. Szczerbicki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cemetary	April 9 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Balto

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

D74595 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D74595

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH St Vincents Infant Asy.

CITY OF BALTIMORE: (No. 1921 division ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Webb Washington

(a) RESIDENCE NO. 1536 4th St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12, 1917

7 AGE — Years: 5 — Months: 6 — Days: 25 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Richard E Webb

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Florence Finch

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Wm E. Webb
(Address) 1548 Penna. Ave

15 Filed APR 8 - 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7- 1923

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to Apr 7, 1923, that I last saw h alive on April 6, 19..., and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. / mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas K. Goldsborough, M. D.

, 19 (Address) 2135 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto — DATE OF BURIAL April 9 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Watt

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be given in years, months and days. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See back of certificate. See instructions on back of certificate. CAUSE OF DEATH is very important.

D74596

✓ D74596

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Stockton N ST. 16 WARD)

2-FULL NAME Jas. Brooks

(a) RESIDENCE. NO. 604 Stockton N. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 18 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	—	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Arthur Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Arthur Brooks.
(Address) 604 Stockton N

15 APR 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 26, 1923, to April 7, 1923, that I last saw h[illegible] alive on April 7, 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis N.C.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Exam

(Signed) Harold Wagner M. D.

4/7/, 1923 (Address) 1706 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saint Leos. DATE OF BURIAL 4/8/23 19

20 UNDERTAKER Saml W Chase & Son ADDRESS 1400 Madison

A. 6.— mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74597

CERTIFICATE OF DEATH.

100-001

D74597

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Shaffer

(a) RESIDENCE NO. 1032 E. Chase St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bath Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 8 6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10 NAME OF FATHER William Shaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Municipal Hospital Records.
(Address)

15 Filed APR 8 - 1923 ROBERT R. KNAPPER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17

I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to April 6, 1923, that I last saw h in live on April 6, 1923, and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

4-7-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Apr 7th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 Monroe St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D74598

CERTIFICATE OF DEATH.

101-001

D74598

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1655 N. Fulton Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W. Graban

(Residence in Baltimore: No. 1655 N. Fulton ave St.; ....yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 17 (Day) 1887 (Year)

7-AGE, 35 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Salesman 166

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Karl Graban

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mamie Burke

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Graban

(Address) 1655 N. Fulton St

15- Filed APR 8 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 30 1923, to Apr. 5th 1923, that I saw h.im alive on April 4th 1923, and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows: Left lobar pneumonia (type I.V.) with pleurisy.

(Duration) ....yrs. ....mos. 5½ ds.

CONTRIBUTORY (Secondary) Meningitis

(Duration) ....yrs. ....mos. 1½ ds.

(Signed) O. L. Hoffman M. D.

4-6-, 1923 (Address) 3409 Walbrook Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetary — DATE OF BURIAL, April 9, 1923

20-UNDERTAKER Wm. Wm. A. S. Pink — ADDRESS 1737 W. Pratt St

N. B.—Every item of information must be properly classified. Each statement should be made so that it may be plainly understood. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement should be made so that it may be plainly understood. See instructions on back of certificate.

D74599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D74599
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1927 Hubert St. ST.: 15 WARD)

2-FULL NAME Mary Virginia Lauf

(Residence in Baltimore: No. 1927 Hubert St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

40 St.; yrs., 6 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Sept. 20, 1882
(Month) (Day) (Year)

7-AGE, 40 yrs. 6 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Robt. F. Stevens

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lydia Joyce

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Lauf

(Address) 1927 Herbert St.

15- APR 8 - 1923 ROBERT R. KRAUTER,
Filed....., 191.... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... yrs. 14 mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)
April 6, 1923 (Address) 200 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, 4/9, 1923

20-UNDERTAKER J. Fred McCully ADDRESS 130 E. Fort

N. B.—Every item of information should be carefully supplied. AGE must be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74600

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74600

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Parish ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Queen

(a) RESIDENCE NO. 2224 Parish ST., ... WARD .....

(Usual place of abode) (But (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced (or) WIFE of George Queen

6 DATE OF BIRTH (month, day, and year) May 11-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Colored Laundry work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Brantford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Geo. Queen 220 E. Biddle St.

15 Filed APR 8 - 1923 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5- 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 2- , 1923 , to Apr. 5- , 1923 , that I last saw h alive on Apr. 4- , 1923 , and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-9 19
20 UNDERTAKER David Fasken	ADDRESS 916 Park Ave

mation should be carefully supplied. Age should be properly classified. Exact statement of OCCUPA-
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Gaines ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74601

CERTIFICATE OF DEATH.

74-002 D74601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 Linden ave ST., 44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Gaines

(a) RESIDENCE NO. 533 Linden ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose A. Gaines

6 DATE OF BIRTH (month, day, and year) June 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or..... min.
63	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Louisa Pulzet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Thos. H. Gaines

(Address) 533 Linden ave

15

APR 8-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1923

17

I HEREBY CERTIFY, That I attended deceased from 1921, 19.., to March 6th 1923.

that I last saw living alive on March 6th 1923

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 9 yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Obvious

(Signed) A. Lee Ellis, M. D.

, 19 (Address) 92 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. | DATE OF BURIAL Apr. 9 19 23

20 UNDERTAKER Chas. H. Johnson 4677 | ADDRESS Caroline

N. B. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74602

CERTIFICATE OF DEATH.

129 D74602

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 E Baltimore ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Washington L. Brown

(a) RESIDENCE NO. 2202 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Brown

6 DATE OF BIRTH (month, day, and year) Aug. 5-18 74

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 15

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer Chesapeake & Co.

9 BIRTHPLACE (city or town) Westminster

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town) Westminster

(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mrs Mary E Brown

(Address) 2008 E Balto Ave

15

APR 8-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923.

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to April 7, 1923, that I last saw h alive on April 7, 1923, and that death occurred, on the date stated above, at 1130 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Uraemia + Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination Urinalysis.

(Signed) Albert Caspberg M. D.

4/8, 1923 (Address) 2027 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Cemetery

DATE OF BURIAL 4/9/23

20 UNDERTAKER Eutaw Place

ADDRESS 1723 Eutaw Pl

N. B. Information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

✓ Smith
118 N. Calhoun

D74603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74603

CERTIFICATE OF DEATH.

Registered No. 164

1-PLACE OF DEATH

City of BALTIMORE: (No. 1608 West Franklin Street Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Watts

(a) Residence No. 1608 West Franklin Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-If married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 10-1849

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) A. A. Co Md

PARENTS.
10-NAME OF FATHER Richards Watts
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Co. Md
12-MAIDEN NAME OF MOTHER Rachel Cunningham
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Co

14- (Informant) Eliz Tucker
(Address) 1608 W. Franklin

15- Filed APR 8 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 2 1923, to April 7 1923, that I last saw him alive on April 6 1923, and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:
Infirmities of age

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. F. Smith, M. D.
April 8, 1923 (Address) 118 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL, April 9 1923

20-UNDERTAKER. Wm Cook — ADDRESS 502 E North Ave

Should be carefully supplied. Exact statement of OCCUPATION is very important, and should be properly classified. In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Witteman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74604

CERTIFICATE OF DEATH.

101-001

D74604

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 5356 Hamilton Av ST. 27 WARD)

2-FULL NAME. William Witteman Sr.

(a) RESIDENCE. NO. 5356 Hamilton Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Witteman

6 DATE OF BIRTH (month, day, and year) July 31st 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 366

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Christ Witteman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schiers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Sophie Witteman

(Address) 5356 Hamilton Ave

15 Filed APR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6th 1923

17

I HEREBY CERTIFY, That I attended deceased from 3-29, 1923, to 4-6, 1923 that I last saw him alive on 4-6-23, 19.. and that death occurred, on the date stated above, at 8:11 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) R. F. Studesh, M. D.

4-6 1923 (Address) Main & Hayward

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	April 1923

20 UNDERTAKER B. Schloman & Son

ADDRESS 1084 Monroe St

Information should be carefully supplied. And the certificate may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74605

CERTIFICATE OF DEATH.

124 D74605

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 792 W. Saratoga ST., 11 WARD)

2-FULL NAME Sophia Banks

(a) RESIDENCE No. 792 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: James Banks

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE: Years 61 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Not known

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Horace Banks

(Address) 792 W. Saratoga st

15 APR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 3rd 1923, to Apr 5th 1923, that I last saw her alive on Apr 3rd 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds. Not known

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry F. Brown, M. D.

, 19 (Address) 1531 Freedman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: N. E. Auburn Cemetery — DATE OF BURIAL: 4/8/23

20 UNDERTAKER: Samuel T. Hagerty — ADDRESS 578 N. Biddle

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated IN YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Sobaszek

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74606 — CERTIFICATE OF DEATH. — 25 — 1923 — D74606

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Town Pier 4 Hall St. St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Joe~~ Edward ~~Sobaszek~~ Sobaszek

(Residence in Baltimore: No. 1007 Curtis Bay ave St. 15 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1..... (Year)

7-AGE. 24 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~Teacher~~
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER, F. Sobaszek

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Mary Swierski

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Sobaszek

(Address) 11 Cypress St

APR 8 - 1923 Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31 (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned

accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

April 7 192 3 (Address) (Coroner) 1089 Light

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Cross Cem DATE OF BURIAL. April 10 1923

20-UNDERTAKER William Kaczorowski ADDRESS 1618 Eastern Ave

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. Exact statement of DISEASE or CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74607

CERTIFICATE OF DEATH.

90 D74607

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 W Saratoga ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Susan Belle Schleier

(a) RESIDENCE NO. 2015 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schleier

6 DATE OF BIRTH (month, day, and year) May 15th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Pendleton Wood.

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mrs Jno Leahy
(Address) 2016 W Saratoga St

15 APR 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1923, to Apr. 6, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Valvular Dis of Heart
& Chronic Bright's Dis

assuming to [illegible] about
(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea caused by senile Collapse
(duration) yrs. mos. Days

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Consultation

(Signed) [signature], M. D.

4/6, 1923 Address) 1605 N Monroe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waynesboro Pa	4/7/23
20 UNDERTAKER Jno H Leahy Sulton & Leahy	ADDRESS Fayette

N. B.—Information should be carefully supplied. AGE should be that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74608

CERTIFICATE OF DEATH.

X 37 D74608

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N. Fawn St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Brown

(a) RESIDENCE. No. 616 N. Fawn St ST., WARD. Huntington W Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. 32 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Irons horseman

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Virginia

12 MAIDEN NAME OF MOTHER Tillie Christmas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Mary Brown

(Address) Huntington W. Va.

15 APR 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 6 - 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1923, to April 6th, 1923, that I last saw h[illegible] alive on April 5th, 1923, and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Drunkenness

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? In Army

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jas O Casper, M. D.

4/7. 19 (Address) 1063 Forrest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Huntington W. Va	4/8 1923
20 UNDERTAKER J. Gleason & Bro	ADDRESS 1127 E Balto st

mation should be furnished. Exact statement of occupation is necessary. If birth certificate cannot be obtained, write "Unknown" or the nearest approximate date. Unless CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. If birth certificate cannot be obtained, write "Unknown" or the nearest approximate date. Unless TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D74609

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2312 E. Balto. ST., 6 WARD)

2-FULL NAME Soloman Mezurinsky

(a) RESIDENCE No. 2312 E. Balto ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct - 1915

7 AGE — Years: 7 | Months: 6 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Benjamin Mezurinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Brann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Louis (Address) 1439 E. Balto St.

15 APR 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to April 6, 1923, that I last saw h[illegible] alive on April 6, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis Chronic (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meyer Ephraim, M. D.

4/6, 1923 (Address) 1904 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehum Hebrew | DATE OF BURIAL: 4/8 1923

20 UNDERTAKER: Jack Louis | ADDRESS: 1439 E Balto St

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Acute Rheumatic Fever.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74610

CERTIFICATE OF DEATH.

D74610

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] Hillside Road St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Childs de Rosset

(a) Residence No. 12 Hillside Road St., 23 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 47 yrs. 7 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ida Randolph de Rosset

6-DATE OF BIRTH (month, day and year) Sept-7-1875

7-AGE 47 yrs. 7 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Eastern Sales Mgr

(b) General nature of Industry, business, or establishment in which employed (or employer) T. H. Symington Co, (about)

(c) Name of employer —

9-BIRTHPLACE (city or town). (State or Country). Wilmington N. C.

PARENTS.

10-NAME OF FATHER. Thos. C. de Rosset

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Wilmington N. C.

12-MAIDEN NAME OF MOTHER. Louise B. Sutton

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Wilmington N. C.

14- (Informant) Mrs Ida R. de Rosset

(Address) 12 Hillside Road

APR 8 - 1923 ROBERT R. KRAUTER,

Filed..... 19.. Clerk or Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 7. 1923

17- "I HEREBY CERTIFY, That I attended deceased from April 7 1923 to April 7 1923

that I last saw him alive on April 7 1923

and that death occurred, on the date stated above, at 4 P. m.

18-CAUSE OF DEATH* was as follows:

Primary Acute dilatation of Heart due to Arterio-Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(Duration) 3 yrs. 4 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Tilson Porter M. D

4/7 1923 (Address) 422 Roland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Wilmington N.C.

DATE OF BURIAL, Apr 8 1923

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. Exact statement of occupation is required. Cause of death must be properly classified, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.–1-10-21–M&T–1500 Bks.

D74611

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74611

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [redacted] Montebello Terrace ST., Lauraville WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna D. Miller

(a) RESIDENCE No. 120 Montebello Terrace ST., Lauraville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Miller

6 DATE OF BIRTH (month, day, and year) June 22 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant William A. Miller (Address) 120 Montebello Ave.

15 FILED APR 8-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1923, to April 6. 1923.

that I last saw h alive on April 6. 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Schuck, M. D.

April 6, 1923 (Address) 4706 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 9 1923

20 UNDERTAKER Fred'k Lassahn & Sons ADDRESS Fullerton

N. B. ... mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa... TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74612

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. D74612

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Mills

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1826

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	96			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 APR 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to April 6, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKoy M. D.

1-7-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 4/9 1923

20 UNDERTAKER Samuel Townsley

ADDRESS 678 W Baltimore

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

poc—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74613

CERTIFICATE OF DEATH.

162 ✓ D74613

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2202 Cambridge St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Poniatek

(a) Residence No 2202 Cambridge St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-Single, ✓ Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 7 1923

7-AGE, ... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Walter Poniatek

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Helen Josienski

13-BIRTHPLACE OF MOTHER (city or town) poland (State or Country),

14- (Informant) Walter Poniatek

(Address) 2202 Cambridge

15- Filed APR 9 - 1923 192 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 8 1923

17- I HEREBY CERTIFY, That I attended deceased from April 7 19 23 to April 8 19 23

that I last saw h... alive on April 8 19 23

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 80 N. Glenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Rosary — DATE OF BURIAL, April 9 1923

20-UNDERTAKER John McWeber — ADDRESS 1803 Bank St

in plain terms, so that it may be properly classified. Exact statements of cause. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74614 HEALTH DEPARTMENT—CITY OF BALTIMORE 112 D74614

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2145 W Saratoga St. 20 WARD)

2-FULL NAME Wm M. Richardson

(a) RESIDENCE. No. 2145 W Saratoga St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes M. Richardson

6 DATE OF BIRTH (month, day, and year) July 2-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. H. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mattie B. Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Agnes M. Richardson (Address) 2145 W. Saratoga St

15 Filed APR 9-1923 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-23

17 I HEREBY CERTIFY, That I attended deceased from April 3rd 1923 to April 6th 1923, that I last saw h[illegible] alive un. April 6th 1923, and that death occurred, on the date stated above, at 7 P M m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Benj Owens M. D.

4/6. 1923 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	April 9 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gave a history of having
Eaten 2 hard boiled
Eggs & caused indigestion

Spec—12-23-21—E.B.R.S.—400 Bks.

D74615 HEALTH DEPARTMENT—CITY OF BALTIMORE D74615

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 44

City of BALTIMORE: (No 4822 Ferndale ave St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Knell

(a) Residence No. 4822 Ferndale ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Charles H. Knell

6-DATE OF BIRTH (month, day and year): June 14 1842

7-AGE: 50 yrs. 9 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Chas F. Pleitner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary E. Dutman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Chas H. Knell

(Address): 4822 Ferndale ave

15- Filed APR 9 - 1923 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Apr 6/23

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Apr 6th, 1923, that I last saw h[illegible] alive on Apr 6th, 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Secondary to Carcinoma of Gall Bladder

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) A. E. Thompson, M. D.

Apr 7, 1923 (Address) 4509 Gelbach Hgts

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Apr 9 1923

20-UNDERTAKER: John O. Mitchell — ADDRESS: 120 W. Lafayette

In plain terms, so that it may be properly classified. Exact statement of occupation required. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16208 D74616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X74-001 D74616

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. St., 27 Ward)

2-FULL NAME Sam Aiken

(a) RESIDENCE No. 211 Longwood Rd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Virginia (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maria Aiken ?

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	55?	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Edward Aiken

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Ann King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed APR 9 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 - 1923

17 I HEREBY CERTIFY, That I attended deceased from March 2. 1923. to April 8. 1923. that I last saw him alive on April 8 - 1923. and that death occurred, on the date stated above, at 7.02 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 27 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bugg M. D.

19 (Address) John Hopk Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill - Balto

DATE OF BURIAL 4-9 1923

20 UNDERTAKER George H. Holland

ADDRESS 1631 Druid Hill Ave

mation should be entered, response, so that it may be properly classified. Exact statement of cause of death
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death
TION is very important. See instructions on back of certificates.

Levinson

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74617

CERTIFICATE OF DEATH.

44 D74617

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 N Bond ST., 5 WARD)

2-FULL NAME Samuel J. Levinson

(a) RESIDENCE NO. 125 N Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Eli Levinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Harry Levinson
(Address) 1218 Bond St

15 Filed APR 9 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to April 8, 1923, that I last saw him alive on April 6, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cancer Gastric

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	April 9 1923
20 UNDERTAKER: May Levinson	ADDRESS 1121 E Balto St

mation should be careful, and precise, so that it may be properly classified. Exact statement of occupation and CAUSE OF DEATH in plain terms

Spec. 1-19-21 - M&T - 1500 Blks.

74618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-101 D74618

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1907 E. Biddle ST., 8 WARD)

2-FULL NAME Mary A Schoeb

(a) RESIDENCE No. 1907 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 50 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of: Wm R Schoeb

6 DATE OF BIRTH (month, day, and year): June 11 1856

7 AGE — Years: 67. Months: ..... Days: ..... If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Danz Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md

12 MAIDEN NAME OF MOTHER: Cathia Leach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant (Address): Wm R Schoeb 1907 E. Biddle

15 Filed: APR 9 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 1923, to Apr 7 1923.

that I last saw h alive on Apr 6 1923,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia.

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) E. A. Schultz M. D.

, 19 (Address) 1107 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Park Wood Cemetery — DATE OF BURIAL: Apl 9. 1923

20 UNDERTAKER: Robt Tilmon Sr — ADDRESS: Ly. Ave

Spec. 1-19-21 - M&T - 1500 Blks. — Exact statement of the information should be carefully supplied. Answers must be full and complete so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the information should be carefully supplied. Answers must be full and complete so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Windfelder

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74619

D74619

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 121 Hawthorn Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John H. Windfelder

(Residence in Baltimore: No. 121 Hawthorn Road St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Nov. 16 1857
(Month) (Day) (Year)

7-AGE. 65 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER. John Windfelder

11-BIRTHPLACE OF FATHER. (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Mary Meisse

13-BIRTHPLACE OF MOTHER. (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Abel

(Address) 2506 Tioga Rd

15- APR 3 - 1923 Filed 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 2 192 3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Heart Disease

(Duration) .....yrs. .....mos. .....ds.

(Signed) John F. Morrison M. D.
(Coroner.)

1923 (Address) 2622 Boundary

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL. 4/9 1923

20-UNDERTAKER. Henry W. Mears & Son ADDRESS 805 N. Calvert

To state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

162579 D74620

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D74620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. " " " ST., 22 9 WARD) JOHNS HOPKINS HOSPITAL.

2-FULL NAME Caroline Gant.

(a) RESIDENCE NO. 807 Peach Alley ST. City WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Carrie Carter (Daughter) 719 Eutaw Pl City

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
76.	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jerry Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed APR 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 6, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Nephritis - chronic

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene leg

(duration) yrs. 8 mos. 14 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of April 3 '23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct — DATE OF BURIAL April 9 1923

20 UNDERTAKER S. K. Brown & Son — ADDRESS 1811 W Mad'g

mation should be given, using, if possible, the terms of the Nomenclature. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74621

74-002 D74621

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., (or WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Blake

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 APR 9-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1923

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1919, to April 4, 1923, that I last saw him alive on April 3, 1923, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Thrombosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

4-5-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cl — DATE OF BURIAL April 9 1923

20 UNDERTAKER J. E. Brown & Son — ADDRESS 108 W Monty

mation should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D74622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D74622

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 Druid Hill Av ST.) 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward W. L. Peck

(Residence in Baltimore: No. 1905 Druid Hill ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Mal

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ..., (Month) (Day) 1874 (Year)

7-AGE, 79 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer) Preaching

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, E. W. Peck

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Amelia Worley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. M. Peck

(Address) 1927 Druid Hill Ave.

15- APR 3 - 1923 Filed....., 191..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1923, to April 6 1923, that I saw him alive on April 5 1923, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 10 ds.

(Signed) H. S. McCord M. D.

4/7, 1923 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Apr. 7, 1923

20-UNDERTAKER John H Joachim ADDRESS 1127 Druid Hill

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 11-001 D74623

74623

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Joseph Gen'l Hosp. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie L. Hollingsworth

(a) RESIDENCE NO. 121 W. Base ST., ... WARD ..... Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of James Hollingsworth

6 DATE OF BIRTH (month, day, and year) January 21-1893

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
30	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James R. Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha D. Gillie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) James Hollingsworth 121 W Base

15 APR 9-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 8, 1923, that I last saw h... alive on April 8, 1923, and that death occurred, on the date stated above, at. 12.09 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. D'Semao, M. D.

, 19 (Address) Saint Joseph Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL: At Mary's Hampden — DATE OF BURIAL April 10, 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E 40th

...may be properly classified. EACH statement of ...
...ck of certificate should be carefully supplied, so that it may be ...
...mation should be carefully supplied, so that it may be ...
CAUSE OF DEATH in plain terms, so that it may be ...
TION is very important. See instructions on back of ...

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74624

CERTIFICATE OF DEATH. 58-001 D74624

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. 2118 E. Baltimore ST., 20 WARD)

2-FULL NAME Charles Wedemeyer Sr.

(a) RESIDENCE NO. 2118 E. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If (married, widowed, or divorced) HUSBAND of (or) WIFE of Rose Wedemeyer.

6 DATE OF BIRTH (month, day, and year) Dec. 7. 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
52	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rose Wedemeyer Sr.
(Address) 2118 E. Baltimore

15 Filed APR 9-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7. 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-17-23, 19..., to 4-7-23, 19..., that I last saw h[illegible] alive on 4-7-23, 19..., and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. F. Wanot M. D.

4/9/23 19 (Address) 1302 E. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park R. Cem.	April 10 1923
20 UNDERTAKER	ADDRESS
Geo. Penn Seipel Sons	1211 E. Baltimore St

mation should be carefully supplied. Data should be so that it may be properly classified. Particulars of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.–1-10-21–M&T–1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74625

CERTIFICATE OF DEATH.

112

D74625

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 E. Washington ST., 8 WARD)

2-FULL NAME John Kaufmann.

(a) RESIDENCE NO. 2000 E. Washington ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Anna H. Kaufmann

6 DATE OF BIRTH (month, day, and year) Oct 8th 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
62	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer) John Kaufmann

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Kaufmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant [illegible] (Address) 2000 E. Washington St.

15 Filed APR 9 – 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1923, to April 7, 1923.

That I last saw him alive on April 7 1923

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos 10 hrs ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chas. H. Bubert M. D.

April 8 1923 (Address) 1100 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. — DATE OF BURIAL April 11, 1923

20 UNDERTAKER Wm. H. Peter & Son — ADDRESS 831 W. Pratt St.

mation should be correctly supplied. Exact statement of occ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74626

CERTIFICATE OF DEATH.

90 D74626

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 156 N. Lakewood Av St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen J. Birckhead

(a) RESIDENCE NO. 156 N. Lakewood Av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Florence E. Birckhead

6 DATE OF BIRTH (month, day, and year) Sept 15-61

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	61	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Shirt factory

(c) Name of employer Wise Bros.

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Birckhead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Florence E. Birckhead (Address) 156 N. Lakewood

15 DATE RECEIVED APR 9-1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Febr 20, 1923, to April 6, 1923.

That I last saw him alive on April 5, 1923

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Kidney disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) A. C. Dean, M. D.

4/9, 1923 (Address) 3901 Harrison.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Apr 9 1923

20 UNDERTAKER Philip Herring — ADDRESS 2016 Orleans

mation should be carefully supplied. Exact statement of COUNTY may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may back of certificates.
TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Blks.

D74627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74627

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 W Lanvale ST., 16 WARD)

2-FULL NAME Charles A Geiselman

(a) RESIDENCE NO. 1532 W Lanvale ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E Geiselman

6 DATE OF BIRTH (month, day, and year) Aug 13, 65

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER John Geiselman

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Garbaugh

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Pa.

14 Informant ..... (Address) 1532 W Lanvale St

15 Filed APR 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1923, to April 6, 1923, that I last saw him alive on April 6, 1923, and that death occurred, on the date stated above, at 530 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia
Diabetic Coma

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. B. Pole, M. D.

, 19 (Address) 2034 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL April 9 1923

20 UNDERTAKER W M Routson — ADDRESS 1238 N Smith

mation should be entered in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74628

CERTIFICATE OF DEATH.

100-002 D74628

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 132 N Augusta St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Gerard Schroder.

(Residence in Baltimore: No. 132 N Augusta St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. March 3 1923
(Month) (Day) (Year)

7-AGE. yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. child
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Harry Schroder

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Lillian Sabel

13-BIRTHPLACE OF MOTHER, (State or Country). New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Balto St.

15- Filed APR 9 - 1923 ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr. 8- 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, aforesaid Inquest find that said deceased came to death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

Cap Bronchities

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) yrs. mos. ds.

(Signed) Geo Claude Bladel M. D.
(Coroner)

(Address) 1436 Bway.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Woods Rd. DATE OF BURIAL, 4-9th 1923

20-UNDERTAKER. Jacob Lewis ADDRESS 1439 E Balto St

N. B.—Every item of information must be given, so that it may be entered in the records in plain terms, so that it may be understood by others than physicians. In particular state CAUSE OF DEATH in plain terms, so that it may be understood by others than physicians. See instructions on back of certificate. is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74629

CERTIFICATE OF DEATH.

74-001

D74629

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hosp ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Alk

(a) RESIDENCE NO. 1532 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 16 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Alk

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hosp Jack Lewis 1439 E Baltimore

15 APR 9-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1923, to April 7, 1923.

that I last saw her alive on April 7, 1923

and that death occurred, on the date stated above, at 3.55a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? none

(Signed) Isidore D. Jay, M. D.

4/7, 1923 (Address) Hebrew

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 4/9 1923

20 UNDERTAKER Jack Lewis 1439 E Balto

ADDRESS

N. B.—WRITE plainly. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5/183

D74630 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... James Arthur Webb .....

(Residence in Baltimore: No..... 1230 Edward ..... St.; yrs.,..9...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	col	

6-DATE OF BIRTH. ..... March 13/1914 ....., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
.....9.....yrs.....mos...24...ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... school boy .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. George Webb

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Francis Waters

13-BIRTHPLACE OF MOTHER, (State or Country). Pocomoke Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Francis Waters Webb .....

(Address)..... 1230 Edward St. .....

APR 9 - 1923 Filed..... 192.....

ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... APRIL 5/23 ....., 192..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquiry ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ..... his ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- self inflicted pistol wound- entered left costal region punctered stom., trans. colon, and liver. ..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY. (Secondary) Shock due to hemorrhage

..... (Duration)..... yrs..... mos..... ds.

(Signed) J. S. H. Toth ..... M. D. (Coroner.)

4/7/23 192.... (Address) 508 E. North Ave. .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	April 9 1923
UNDERTAKER,	ADDRESS
R. B. Groll	1405 W. Eldersley

N. B. ... state CAUSE OF DEATH in plain terms, so that it may ... is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74631

D74631

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay view Hospt. St. H S WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Brown

(a) RESIDENCE NO. 214 W. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 (Single, Married, Widowed, or Divorced, (write the word)): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): unknown

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Cornelia Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): John Brown 826 N. Bond St.

15 Filed APR 9—1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/20, 1923, to 4/8, 1923, that I last saw him alive on 4/8, 1923, and that death occurred, on the date stated above, at 1.05 p m

The CAUSE OF DEATH* was as follows:

1a. pericarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 4/5/23

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. M. Powell, M. D.

, 19 (Address) Bay View Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury — DATE OF BURIAL: April 9 1923

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

mation should be carefully supplied. Exact statement of DISEASE may be properly classified. CAUSE OF DEATH in plain terms, so that it may back of certificates. TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74632

CERTIFICATE OF DEATH.

71-002 D74632

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Fairmont Ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Mary Blackstone

(a) RESIDENCE. NO. 1402 Fairmont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? yrs. 13 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Feb 22 - 22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Blackstone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Liverpool England

12 MAIDEN NAME OF MOTHER Lizzie Dunlop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Josephine Blackstone
Address 1402 Fairmont Ave

15 Filed APR 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to April 6, 1923, that I last saw h[illegible] alive on April 6, 1923, and that death occurred, on the date stated above, at 5. 6. m.

The CAUSE OF DEATH* was as follows:

Enteritis - Acute Bronchitis Toxemia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) 2.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of ...

Was there an autopsy? Yes Pathologic Report

What test confirmed diagnosis? Hospital Report

(Signed) Joseph L. Goldstein M. D.

(Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL April 10 1923

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74633

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D74633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2628 Hudson (St.) 1 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kostancya Kuchta

(a) RESIDENCE. No. 2628 Hudson St., 1 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1871-April 4

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Kietzak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Kuchta
(Address) 2628 Hudson St

15 Filed APR 9 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/14 . 1921 . to April 7 . 1923 that I last saw h[er] alive on April 6 . 1923 and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

4/9 19 23 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	April 10 1923
20 UNDERTAKER	ADDRESS
Stephen Stefankowski	1005 Fleming Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74634

CERTIFICATE OF DEATH.

74-001 D74634

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 249 N. Bruce St ST., 19 WARD)

2-FULL NAME Samuel Maddox

(a) RESIDENCE NO. 249 N. Bruce ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Son of Kate Maddox

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) James Town Md

PARENTS

10 NAME OF FATHER Sam J Maddox

11 BIRTHPLACE OF FATHER (city or town) (State or country) James Town Md

12 MAIDEN NAME OF MOTHER Kate Hand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) James Town Md

14 Informant Howard Bolar
(Address) 249 N Bruce St

15 Filed APR 9-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1923, to April 6, 1923, that I last saw him alive on April 6, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy & Palpitations of Heart
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Palpitations of Heart
apoplexy (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr Gill Kennard M. D.

4-6, 1923 (Address) 708 Enoch St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lorn Station Lumbard & Co	Apl 9 1923
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Ashland &

Spec.—1-10-21—M&T—1500 Bks.

D74635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74635

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 N. Belvedere Av. ST., 27 WARD)

2-FULL NAME Thomas A. Dauhaus

(a) RESIDENCE NO. 143 N. Belvedere Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Anthony W. Dauhaus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Loretta T. Cassidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Anthony W. Dauhaus

(Address): 143 N. Belvedere Ave

15 Filed APR 9 - 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to Apr 5, 1923,

that I last saw him alive on Apr 4, 1923,

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

4/9/23 (Address) 1735 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Rom Govans

DATE OF BURIAL: 4/9 1923

20 UNDERTAKER: Chas. P. Evans & Son

ADDRESS: 1180 W. Mt. Royal Ave

REFUSE ROOM FOR ERASURES. EXACT INFORMATION is required. It may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

January

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74636 HEALTH DEPARTMENT—CITY OF BALTIMORE D74636

CERTIFICATE OF DEATH. 31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 Mosher ST. 16 WARD)

2-FULL NAME Samuel Herman Kussmaul

(a) RESIDENCE. No. 1221 Mosher ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Agnes Kussmaul

6 DATE OF BIRTH (month, day, and year): Sept 7, 1864

7 AGE: Years 58 1/2 yrs. Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman 086

(b) General nature of Industry, business, or establishment in which employed (or employer): Pipe Supply Place

(c) Name of employer: Wallace Stevens

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm. F. Kussmaul

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marguerite Winzle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (wife) (Address) 1221 Mosher ST. ROBERT H. KAUFFER.

APR 9 - 1923 Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1923, to April 8, 1923.

that I last saw him alive on April 8, 1923.

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB. (actue)

(duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil Pfeiffer, M. D.

4/8 1923 (Address) 2902 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park.

DATE OF BURIAL: 4/11/23

20 UNDERTAKER: Martin Fahey & Sons

ADDRESS: 1234 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

D74637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D74637

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp ST., 12 WARD)

2-FULL NAME Rose Russo

(a) RESIDENCE NO. 4618 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. 27 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 29, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip Russo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Rose Papale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Mrs Rose Russo

(Address) 4618 York Road

15 APR 9-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1923 to April 7, 1923.

that I last saw her alive on April 7, 1923

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia both lungs,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank P. Maimo, M. D.

, 19 (Address) Preston St. Vance Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr. 9 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact nativity of parents required. TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74638

CERTIFICATE OF DEATH.

100-001 D74638

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 873 N. Fayette ST., 18 WARD)

2-FULL NAME Veronica Anderson,

(a) RESIDENCE NO. 873 N. Fayette ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Sex~~ Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —— Feb.

6 DATE OF BIRTH (month, day, and year) Feb. 11. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ~ hrs. or ~ min.
	—	1 —	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Wilson Anderson,

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Teresa Breen,

13 BIRTHPLACE OF MOTHER (city or town) Laurel
(State or country) Md.

14 Informant (Address) Teresa Breen, 873 N. Fayette St.

15 Filed APR 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 5, 1923, to Apr. 9. 1923, that I last saw him alive on Apr. 8, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia.
(Primary)
(duration) ~ yrs. ~ mos 4 ds.

CONTRIBUTORY none
(Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Signs.

(Signed) J. Chas. Norton, M. D.

, 19 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt. Lookout Cemetery

DATE OF BURIAL Apl 10 1923.

20 UNDERTAKER Wm. F. Gouvan & Son.
Ed. F. Gouvan

ADDRESS 901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74639

CERTIFICATE OF DEATH.

129 D74639

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Milton ST., 1 WARD)

2-FULL NAME Joseph John Gebhardt.

(a) RESIDENCE NO. 607 S. Milton ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Gebhardt.

6 DATE OF BIRTH (month, day, and year) Jan 31st 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
44	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John G. Gebhardt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Magdalena Smette

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sarah E. Gebhardt.

(Address) 607 S. Milton ave.

APR 9 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to April 7, 1923,

that I last saw him alive on April 6, 1923,

and that death occurred, on the date stated above, at 9 59 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Dr. Hill M. D.

4/9/23, 19 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 10 1923

20 UNDERTAKER Lilly & Geiler ADDRESS 1033 N. Wolfe

mation should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74640 HEALTH DEPARTMENT—CITY OF BALTIMORE D74640

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N North Ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey A. Storm

(a) RESIDENCE NO. 706 N North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1 1859

7 AGE Years 63 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper Painter .50

(b) General nature of industry, business, or establishment in which employed (or employer) R. R. Service

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Storm

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Katherine Shenk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Adm. C. Storm (Address) 706 N North Ave

15 Filed APR 9-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to April 8, 1923, that I last saw him alive on April 8, 1923, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab & B.P.

(Signed) Horace W. Byers, M. D.

(Address) 749 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boonsboro, Md. DATE OF BURIAL 4-9th 1923

20 UNDERTAKER E & B Hartle ADDRESS 1156 West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74641
1-PLACE OF DEATH

CERTIFICATE OF DEATH. 1 179

D74641
Registered No. C.....

City of BALTIMORE: (No. Hebrew Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Rachel Schiller

(Residence in Baltimore: No. 1450 N. Gilmor St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. unknown 1853
(Month) (Day) (Year)

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto St

15- APR 9 - 1923 Filed 192.

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental = Burns 3 days
Despair from pain to shoulder,
Clothes caught fire while
singing at Candle Mch 30 1923
CONTRIBUTORY (Secondary) Nephritis (Duration) yrs. mos. ds.

(Signed) J S A Potter M. D.
(Coroner.)
4/9 1923 (Address) 508 E North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
Hebrew Brethren Cem. April 9 1923

20-UNDERTAKER. ADDRESS
Jack Lewis, 1439 E Balto

IN ALL CASES state CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74642

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH So. Dispensary.

CITY OF BALTIMORE: (No. 1401- Division ST. 14 WARD)

2-FULL NAME Bernadette Heaney.

(a) RESIDENCE NO. St. Vincents Inf. Asy. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22nd 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant St Vincent Infant Asylum
(Address)

15 Filed Robert F. Harrison, Registrar

9-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1923, to April 7, 1923, that I last saw him alive on April 7, 1923, and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. R. Goldsborough Jr. M. D.

, 19 (Address) 2735 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 4/9/23 19

20 UNDERTAKER Martin Fahey & Sons — ADDRESS 827 N. Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of contributory causes is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74643

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74643

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) German Aged Home ST.: 20 (WARD)

2-FULL NAME Henriette Weinlandt

(a) RESIDENCE. NO. German Aged Home ST.. WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Weinlandt.

6 DATE OF BIRTH (month, day, and year) April 7 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER F. Vocke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Faust

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant Records German Aged Home

(Address) Baltimore and Lapsom St

15 ROBERT F. Harrison, . 19

9-1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to April 7, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John I Hoff, M. D

. 19 (Address) 1843 20 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Apr 9 19 23

20 UNDERTAKER Dept B Cook ADDRESS 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Date statement of TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74644

D74644

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 N Brice ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry H. Rhoads

(a) RESIDENCE. No. 422 N Brice ST., 20 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J Rhoads

6 DATE OF BIRTH (month, day, and year) Aug

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64	64	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

031

9 BIRTHPLACE (city or town) (State or country) Chapman Pa

PARENTS

10 NAME OF FATHER Chas Rhoads

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredrk Md

12 MAIDEN NAME OF MOTHER Kate Hetzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dalsburg Pa

14 Informant Daughter Mrs Jesse Maynard

(Address) 422 Mulberry St

15 Robert P. Harrison, Registrar

R 9-1923 .19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6- 1923

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1923, to April 6, 1923, that I last saw alive on April 6, 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ruy Overleary, M. D.

6, 1923 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	April 10 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Date of death must be given. Do not use abbreviations. Name of disease alone is insufficient. Example: Pneumonia, Typhoid Fever, Cancer, Tuberculosis, Apoplexy, Heart Disease, Nephritis, Accident, Suicide, Homicide, Childbirth, Abortion, Old Age, etc. Indefinite terms, such as Blood Poisoning, Septicemia, Pyemia, Uremia, Exhaustion, Convulsions, Paralysis, Debility, Marasmus, Tumor, Abscess, Ulcer, Cardiac Disease, Kidney Disease, Liver Disease, Lung Disease, Stomach Trouble, Bowel Trouble, Fever, Inflammation, Hemorrhage, Meningitis, Spinal Meningitis, Brain Fever, Locomotor Ataxia, Gangrene, Jaundice, Premature Birth, Stillborn, Fetus, Child, Infant, Premature Labor, Miscarriage, Still Birth, Unknown, Not Known, Not Ascertained, Not Certified, Not Diagnosed, Not Given, Not Stated, Not Known, Not Ascertained, Not Certified, Not Diagnosed, Not Given, Not Stated, are not sufficient. Deaths from Violent Causes must state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

THIS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D74645

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Hanover ST., 22 WARD)

2-FULL NAME Catherine Phipps

(a) RESIDENCE No. 603 Hanover ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 26 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George H Phipps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anna Arundel Co

12 MAIDEN NAME OF MOTHER Catherine Powers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Woodberry Md

14 Informant George H. Phipps (Address) 603 Hanover St

R 9-1923 Robert P. Harrison, Registrar

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr, 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr, 6, 1923, to Apr, 9, 1923, that I last saw her alive on Apr 8, 1923, and that death occurred, on the date stated above, at 12 45 a/m.

The CAUSE OF DEATH* was as follows:

Spontaneous Hemmorhage

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Premature 7½ mo duration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Transfusion Date of 4/7/23

Was there an autopsy? no

What test confirmed diagnosis? Treated @ University Hospital 4/7/23

(Signed) David Stanchfield M. D.

4/9 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phipps Cemetery Anna Arundel Co.	April 10 1923
20 UNDERTAKER	ADDRESS
A Howard Evans	1428 N Charles St

MATTER SHOULD BE PROPERLY CLASSIFIED. EXACT STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D74646

HEALTH DEPARTMENT—CITY OF BALTIMORE D74646

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Madison Ave ST., 14 WARD)

2-FULL NAME Leon Schiff

(a) RESIDENCE NO. 1906 Madison Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto-Md

PARENTS

10 NAME OF FATHER Meyer Schiff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederick Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Abe Schiff

(Address) 1906 Madison Ave.

15 Robert P. Harrison, Registrar

MAR 9-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1923, to death, 19....., that I last saw h[illegible] alive on April 8, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary oedema -

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

April 9, 1923 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cemetery	April 10 1923
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74647

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 Lookenpaw ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert M Brown

(a) RESIDENCE No. 37 Lookemp ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Brown

6 DATE OF BIRTH (month, day, and year) Mar 10-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	~	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Cassidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frank Brown

(Address) 37 Lookenpaw Ave

15 1923 APR 9 1923 .19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2 .1923. to April 8 .1923.

that I last saw him alive on April 7 .1923.

and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

1923 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 10 1923

20 UNDERTAKER H. C. Wiedefeld

ADDRESS 814 Fremont Ave

Deputy City Clerk

Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of each item is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74648

D74648

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1130 Forrest ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James P. Dailey

(a) RESIDENCE No. 1130 Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22—

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	41	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John L. Dailey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Rose A. Reynolds

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Rose A. Rogers

(Address) 1130 Forrest St

Robert F. Harrison,

Burial Permit Clerk. Registrar

R 9-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1 1923 to Apr 7 1923.

that I last saw h— alive on Apr 7 1923.

and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmon tuberculosis

Duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmon edema fr hrt

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Every one

(Signed) M. D.

. 19 (Address) 1054 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral April 10 1923

DATE OF BURIAL

20 UNDERTAKER H.C. Wiedefeld 918 Fremont

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74649

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N. Streeper ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Litchkey

(a) RESIDENCE NO. 22 N. Streeper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara Litchkey

6 DATE OF BIRTH (month, day, and year) Aug 4/1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Platform Manz

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Sa. Co. Balto. Md 1886

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George Litchkey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Johanna Rosband

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Miss Anabelle Litchkey

(Address) 22 N. Streeper St.

15 Robert P. Harrison,

16 Registrar

Burial Permit Clerk.

R 9-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1923, to April 6, 1923.

that I last saw ~~him~~ alive on April 6, 1923

and that death occurred, on the date stated above, at 10 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Cerebrum

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maxwell Emery M.D.

(Address) 314 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL April 10 1923

20 UNDERTAKER Geo. J. Kerr

ADDRESS 1530 E. Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74650

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 McCulloh ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Stanley

(a) RESIDENCE NO. 1519 Jackson ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~: Mary Morris

6 DATE OF BIRTH (month, day, and year): [illegible], 1857

7 AGE: Years 66; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Garage

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Edw. Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John Stanley

(Address): 1519 Jackson St.

15 Apr 9 1923

Robert P. Harrison,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr, 7 1923

17

I HEREBY CERTIFY, That I attended deceased from June, 10, 1922 to Apr, 7, 1923.

that I last saw him alive on Apr, 6, 1923,

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) — yrs. 10 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? X ray

(Signed) Dan Stanchin, M. D.

4/9, 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A.M.E.

DATE OF BURIAL: Apr 9 1923

20 UNDERTAKER: [illegible]

ADDRESS 1314 Eutaw St

may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74651

CERTIFICATE OF DEATH.

101-001

D74651

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2414 Madison ave. St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Otto

(a) RESIDENCE. No. 2414 Madison ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 5 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER August Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Cath Denton
(Address) 1 W. Heath st

15 Filed ..., 19...

Robert P. Harrison, Registrar

Burial Permit Clerk.

9-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1923, to April 7, 1923,

that I last saw her alive on April 7, 1923,

and that death occurred, on the date stated above, at 1245 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia - 36th day

(duration) ... yrs. ... mos. 17 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos R. Johnson, M. D.

April 7, 1923 (Address) 3928 Park Hts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Apr 10 1923
20 UNDERTAKER	ADDRESS
F. A. Kramer & Son	708 Pennsylvania

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74652 ✓ 129 D74652

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 909 S Charles ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Belt

(a) RESIDENCE. NO. 909 S Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Belt

6 DATE OF BIRTH (month, day, and year) Sept 21 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Picture Frame Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Dept Store

(c) Name of employer Stewart & Co

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Leonard Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Rose Belt
(Address) 909 S Charles St

15 Filed APR 9-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to Apr 7, 1923, that I last saw him alive on Apr 7, 1923, and that death occurred, on the date stated above, at 10 00 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) hypertension + cardiac decompensation (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Mullestiffer, M. D.

4/9, 1923 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Apr 10 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificate may be returned for correction if not satisfactory. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74653 HEALTH DEPARTMENT—CITY OF BALTIMORE D74653

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Redwood ST.; 4 WARD)

2-FULL NAME Annie Eliza Mc Glennon

(a) RESIDENCE. NO. 703 Redwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mitchell Mc Glennon

6 DATE OF BIRTH (month, day, and year) June 23rd 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER J. A. Schimp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Kathrine Blum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Mrs Rose Roberts (Address) 703 Redwood.

15 9-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1923., to April 7, 1923.,
that I last saw her alive on April 7, 1923.,
and that death occurred, on the date stated above, at 10.00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Cont Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) John S. Bishop, M. D.

19 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Apr 10 1923
UNDERTAKER	ADDRESS
L. P. Fussellbaugh	2620 Ct Paul St

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74654

CERTIFICATE OF DEATH.

185 D74654

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lake Court Apart. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Kahn

(a) RESIDENCE NO. Lake Court Apart. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Kahn

6 DATE OF BIRTH (month, day, and year) July 11, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	79	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Howard Kahn

(Address) Lake Court Apts.

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

9-1923

CAUSE OF DEATH in plain terms, so that it may be properly coded. See back of certificates.
TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-1923

17

I HEREBY CERTIFY, That I attended deceased from 4-5-, 1923, to 4-8-, 1923.

that I last saw him alive on 4-8-23, 19....

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

(1) Inter cranial Hemorrhage

Traumatic

(2) R. Coronary Thrombosis

(duration) yrs. mos 3

CONTRIBUTORY (Secondary) Extradural fall from window

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) W. J. Coleman, M. D.

. 19 (Address) 2810 Chelsea Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohel Shalom Cem.

DATE OF BURIAL 4/10/1923

20 UNDERTAKER David Sandheim

ADDRESS 118-20 W. Royal Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74655

CERTIFICATE OF DEATH.

101-001

D74655

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4030 Church ST. 13 (WARD)

2-FULL NAME Georgia Miller Boring

(a) RESIDENCE NO. 4030 Church St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ephraim Boring

6 DATE OF BIRTH (month, day, and year) Oct 31 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
52.	5	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md.

PARENTS

10 NAME OF FATHER Silas Stockdale

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md.

12 MAIDEN NAME OF MOTHER Sarah Fitters

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Ephraim Boring
(Address) 4030 Church St.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9. 1923.

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 1923, to 4/9, 1923, that I last saw her alive on 4/9, 1923, and that death occurred, on the date stated above, at 315 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/9 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury M.E. Cemetery Kristinstown	April 11 1923
20 UNDERTAKER	ADDRESS
J. Walter Davis	3307 Pine St

CAUSE OF DEATH in plain terms, so that it may be properly ... TION is very important. See instructions on back of certificates.

R 9-1923

Spec.–1-10-21 M&T 1500 lbs.

D74656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74656

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2828 Harford Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina C Broache

(a) RESIDENCE NO. 2828 Harford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Broache

6 DATE OF BIRTH (month, day, and year) April 25th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lucia Mathias

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward Broache

(Address) 2828 Harford ave.

15 4-9-1923 Robert F. Hartbol 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1919, to April 7, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 9- P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 5/1921

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G E Buxton, M. D.

4/9, 1923 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	April 19 1923
20 UNDERTAKER	ADDRESS 1034
E Schuloman & Son	Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74657

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D74657

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 622 W. Mulberry ST. 17 WARD)

2-FULL NAME George Bailey, Jr.

(a) RESIDENCE. No. 622 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/29/22

7 AGE — Years: — Months: 11 — Days: 9 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Bailey, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Wilson 4/9/23

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Florence Bailey 622 Mulberry St.

15 4-9-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/ 1923

17

I HEREBY CERTIFY, That I attended deceased from 4/2/ 1923, to 4/8/ 1923,

that I last saw him alive on 4/7/ 1923,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Primary) (duration) 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. P. Harrison M. D.

1923 (Address) 1216 E. H. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 10 1923
20 UNDERTAKER	ADDRESS 114 N.
Bennett Lee and Schroder	

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D74658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74658

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 Fremont ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bennie Cornish

(a) RESIDENCE NO. 1330 N. Fremont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Georgia Cornish

6 DATE OF BIRTH (month, day, and year) Oct 19. 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) p86

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William Cornish

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Flynn

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Henrietta Curtis

(Address) 920 Saint Ann St

15 Filed Robert P. Harrison, Registrar

9 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1923, to Apr 7, 1923, that I last saw h alive on Apr 6, 1923 and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows:

Osteo myelitis & cellulitis of right leg

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

4/9, 1923 (Address) 928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 10 1923
20 UNDERTAKER Brown & Freeland	ADDRESS 1140 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required. Indefinite terms, such as "Heart Disease," "Pneumonia," "Cancer," "Tuberculosis," "Paralysis," "Convulsions," "Old Age," "Infantile Debility," "Premature Birth," "Accident," "Fracture," "Drowning," "Burns," "Homicide," "Suicide," "Found Dead," "Sudden Death," "Coroner's Case," "Unknown," "Not Known," "Not Stated," "Not Given," "Not Ascertained," "Not Certified," "Not Known," "Not Stated," "Not Given," "Not Ascertained," "Not Certified," are not sufficient. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74659 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D74659

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 146 W. Hamburg ST.: 23 WARD)

2-FULL NAME Gladys Day

(a) RESIDENCE. No. 146 W Hamburg ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 22 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dora Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Dora Gray
(Address) 146 W Hamburg St

15 Filed APR 10 1923 .19 ROBERT N. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/1923

17 I HEREBY CERTIFY, That I attended deceased from 4/1/23 to 4/8/23, that I last saw h alive on 4/7/23, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Capillary Bronchitis — 2 ds.
(duration) yrs. mos.

CONTRIBUTORY (Secondary) Influenza — 3 ds.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Tom Bowles, M. D.
4/9/23 (Address) 908 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Apr. 10 1923

20 UNDERTAKER John H. Soadin — ADDRESS 147 Hicks St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations not allowed. Diseases peculiar to females, state whether single, married, widowed or divorced. Deaths from violence, state whether accidental, suicidal or homicidal. Deaths during childbirth, state whether single, married, widowed or divorced. Deaths during childbirth, state whether single, married, widowed or divorced. Deaths during childbirth, state whether single, married, widowed or divorced. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74660

CERTIFICATE OF DEATH.

31 D74660

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 Dolphin ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Jones

(a) RESIDENCE. NO. 235 Dolphin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Jones

6 DATE OF BIRTH (month, day, and year) July 5, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Usual

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Gloucester Co Va

PARENTS

10 NAME OF FATHER: Simon Gales

11 BIRTHPLACE OF FATHER (city or town) (State or country): Gloucester Co Va

12 MAIDEN NAME OF MOTHER: Elizabeth Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Gloucester Co Va

14 Informant: Robert Jones (Address) 235 Dolphin St

15 Filed APR 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to April 8, 1923, that I last saw h er alive on April 7, 1923 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Florida 7+

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Segnel of La Grippe

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) William H Wright, M. D.

April 8, 1923 (Address) 1209 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Blay Banks VA	4-10-1923
20 UNDERTAKER: Daniel Easton	ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D74661

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

CERTIFICATE OF DEATH.

4 74 D74661

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 Park av ..... St., 4 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Chas Sing
Chas Wong
Chas Moon 114 Park av

(Residence in Baltimore: No. ..... St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Chinese

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Dont Know ..... 1.....
(Month) (Day) (Year)

7-AGE. 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Waiter
(b) General nature of industry, business, or establishment in which employed (or employer). 070

9-BIRTHPLACE, (State or Country). Chinese

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). Chinese

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country). Chinese

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Moon

(Address) 114 Park av

15. APR 10 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
..... (Duration) ..... yrs. April mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Gorman M. D.
(Coroner.)

4 7 1923 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Cemetery DATE OF BURIAL. April 10 1923

20-UNDERTAKER. John O. Mitchell ADDRESS 1201 W. Fayette St

state CAUSE OF DEATH in plain terms, as per directions on back of certificate. It is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74662

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

CERTIFICATE OF DEATH.

D74662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sorrendo Sarnito.

(a) RESIDENCE NO. 428 Glen Edward Ave WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: m

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): January

7 AGE — Years: 58 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: John Sorrendo Sarnito

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosi Sorto

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): John Sorrendo Sarnito 428 Glen Edward Ave

15 Filed APR 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1923

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to April 8, 1923, that I last saw him alive on April 8, 1923, and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Secondary post operative pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Hemotomy - Bilateral Hernia (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? At work

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. Isaacs, M. D.

Ap. 8, 1923 (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents Cemetery — DATE OF BURIAL: 4/10 1923

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be a property classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74663

CERTIFICATE OF DEATH.

D74663

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 Light St. ST., 23 WARD)

2-FULL NAME Margaret Haslup

(a) RESIDENCE NO. 1832 Light St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Benjamin F. Haslup

6 DATE OF BIRTH (month, day, and year) June 4 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	32	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Benjamin F. Haslup
(Address) 1832 Light St.

15 Filed APR 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to April 7, 1923
that I last saw h[illegible]ive on April 7, 1923
and that death occurred, on the date stated above, at 7 PM m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D.

April 9, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 4/10 1923

20 UNDERTAKER J. Fred McCully

ADDRESS 430 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74664

CERTIFICATE OF DEATH.

129 D74664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3431 E. Baltimore St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Capt John Johnson

(a) RESIDENCE NO. 3131 E. Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word).
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie E Johnson

6 DATE OF BIRTH (month, day, and year) Dec 1 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Captain. 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Denmark (State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant Mrs Jennie E Johnson (Address) 3131 E Balto St.

15 Filed APR 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 '23 to Apr 7 '23.

that I last saw he alive on Apr 7. 19

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Am Legation,

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinic evidence

(Signed) Thos Insley, M. D.

4/8 19 (Address) 2958 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL April 19

20 UNDERTAKER John Gilbert

ADDRESS 2008 Orleans

mation should be careful... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74665

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3533 E Fairmount ST., Ward 26)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Elizabeth Dunlap

(a) RESIDENCE NO. 3533 E Fairmount ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 13-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	22	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Telephone Operator
(b) General nature of industry, business, or establishment in which employed (or employer) 066
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm B Dunlap

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Katherine Lauf

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Katherine Noonan
(Address) 3533 E Fairmount

15 APR 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-2, 19 23, to 4-7, 19 23
that I last saw h[illegible] alive on 4-7, 19 23
and that death occurred, on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	April 9 1923
20 UNDERTAKER John Ullrich	ADDRESS 248 S Exeter

mation should be careful... Exact ... 12 x 12 x 2.39
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D74666

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 14 WARD)

2-FULL NAME Jennie Hill

(a) RESIDENCE NO. 618 Mosher St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hill Sr

6 DATE OF BIRTH (month, day, and year) Apr 16 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John T. Hill Sr 618 Mosher St

15 Filed APR 10 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to April 6, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Oedema - carcinoma of cervix & bladder (primary)

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma L. Wrainy, M. D.

(Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn DATE OF BURIAL Apr 10 1923

20 UNDERTAKER Wm. M. Chase & Son ADDRESS 1403 Mosher

BEFORE WRITING, READ CAUSE OF DEATH in plain terms, so that it may be properly classified. IMPORTANT ATTENTION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74667
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

6

1/0 D74667
Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine King

(Residence in Baltimore: No. 20 N. Ellwood Ave. St.; yrs. 42 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write this word.)
female	white	

6-DATE OF BIRTH. March 6/1881 (Month) (Day) 1..... (Year)

7-AGE.	If LESS than 1 day,
42 yrs. 1 mos. 1 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Household
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. George Yoe

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lawrence King

(Address) 20 N. Ellwood Ave.

15- Filed APR 10 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorruage - Pistol wound through Left parietal region suicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J S H Collins M. D.
(Coroner.)

4/10/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	4/10/ 1923
20-UNDERTAKER. J A Moran	ADDRESS 3000 E. Baltimore

state CAUSE OF DEATH in plain terms, so that it may be properly classified. is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Cleary.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74668

74668

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 627 Sterling ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Virginia

2-FULL NAME James Cleary

(a) RESIDENCE NO. 627 Sterling St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE C | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0-40

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Warren Cleary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Agnes Marion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Flonce Clary 627 Sterling St

15 APR 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr-7 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to Apr. 7, 1923, that I last saw him alive on Apr. 5, 1923, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulm Tuberculosis

(Duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert H. Levy, M. D.

4/7/23 (Address) 1235 E. Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cemetery — DATE OF BURIAL: April 6 1923

20 UNDERTAKER: Edward Bryan — ADDRESS 631 Orleans St

mation should be carefully supplied. Each item should be properly classified. Each question should be answered so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D74669

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 N Fulton Ave ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Late

(a) RESIDENCE. No. 547 N. Fulton ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 80	—	—	/

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Anna Schriver

(Address) 547 N Fulton Ave

15 Filed APR 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1922, to April 6th 192, that I last saw h[illegible] alive on April 6 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis of Heart

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Personal Examination

(Signed) Wm Grant, M. D.

, 19 (Address) 3043 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 9 1923

20 UNDERTAKER W M Rowton

ADDRESS 230 E Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec—140-21—M&C—1500 Blks.

D74670
162-1918
Med

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D74670

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Weaver

(a) RESIDENCE NO. 544 E. 30th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 years mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
~~WIFE of~~ HUSBAND of Ida Allen Weaver

6 DATE OF BIRTH (month, day, and year) Feb 28-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Jas. S. Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.S.

12 MAIDEN NAME OF MOTHER Eliza Wickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 FILED APR 10 1923 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17

I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to April 8, 1923.

that I last saw him alive on April 8, 1923,

and that death occurred, on the date stated above, at 10 10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs 6 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E Bowles Andrus M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Apr. 11 1923

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74671 46 D74671

D74671

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1926 Edmondson Ave ST., 16 WARD)

2-FULL NAME Lula Bettie Ryan

(a) RESIDENCE NO. 1926 Edmondson Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Thornton A. Ryan

6 DATE OF BIRTH (month, day, and year) Nov 27 1850

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or.... min.
67	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nelson Co. Virginia

PARENTS

10 NAME OF FATHER Samuel Rogers Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nelson Co. Va

12 MAIDEN NAME OF MOTHER Lucinda Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nelson Co. Va

14 Informant Mrs William T. Bryan
(Address) 514 E. Fayette Baltimore Md

15 APR 10 1923 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5th 1923 to April 9th 1923, that I last saw her alive on April 8th 1923, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Thrombosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Cervix

Uterus (duration) 2 yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Boulton M. D.

(Address) 3909 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL April 11 1923

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2173 Penn

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D74672 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74672

CERTIFICATE OF DEATH. 49

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Hospital St., 76 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Cohen

(Residence in Baltimore: No. 1101 S. Clinton St; yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write this word.)
male	white	married

6-DATE OF BIRTH. unknown 1..... (Month) (Day) (Year)

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Harry Cohen

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Ida Codie

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Balto. Md.

15- APR 10 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Plueral Effusion- Neoplasm in chest (Duration) yrs. mos. ds.

(Signed) J S H Davis M. D. (Coroner.)

4/10/23 192.. (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	4/10 '23

20-UNDERTAKER,	ADDRESS
Jack Lewis	1434 E Balto St

state CAUSE OF DEATH in plain terms, so that it may be understood. Do not use abbreviations or terms of doubtful meaning. Be sure that every item is correctly answered. Do not leave any item unanswered unless it is very important. See instructions on back of certificate.

(Jane E. Delahay.)

D74673

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D74673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 5113 Nelson St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane E. Delahay

(Residence in Baltimore: No. 5113 Nelson St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec. 3rd 1851.
(Month) (Day) (Year)

7-AGE, 71 yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Mark Eden

11-BIRTHPLACE OF FATHER, (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. King

(Address) 5113 Nelson Ave

Filed APR 10 1923

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 9 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. H. Morrison M. D.
(Coroner.)

April 9 1923. (Address) 3632 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	April 13 1923

20-UNDERTAKER.	ADDRESS
E. Schlosmans Son	1034 Hanover St

state CAUSE OF DEATH in plain terms, so that it may be understood. This is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74674

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D74674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 30 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Gertrude E. McAllister

(a) RESIDENCE NO. 2680 Wilkins Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert E. McAllister

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 031

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Not Known

14 Informant Robert E. McAllister
(Address) 2680 Wilkins Ave

15 Filed APR 10 1923, 19 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

BEFORE WRITING read carefully the directions printed on back hereof. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 2, 1923, to Apr. 9, 1923, that I last saw h alive on Apr. 9, 1923 and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchial Affection.

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edward F. Kattowski, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. — DATE OF BURIAL Apr. 12 1923

20 UNDERTAKER Margaret D. Flynn — ADDRESS 14 n Eutaw St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74675

CERTIFICATE OF DEATH.

118-00

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Leadenhall ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie A Sanford

(a) RESIDENCE. NO. 1111 Leadenhall ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Frank Sanford

6 DATE OF BIRTH (month, day, and year) July 1 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife at home odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) W. F. Sanford Maple Lawn Avenue

15 Filed APR 10 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 29, 1923, to Apr 9, 1923, that I last saw her alive on Apr 9, 1923, and that death occurred, on the date stated above, at 10.00 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Strangulated femoral hernia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clyx

(Signed) Wade Stigler, M. D.

4/10 1923 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Apr. 11 1923

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74676

CERTIFICATE OF DEATH.

101-001

D74676

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 McCulloh St. ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Williams Green

(a) RESIDENCE. NO. 1030 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October, 1881

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) United Fruit Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James W. Green

11 BIRTHPLACE OF FATHER (city or town) Petersburg, (State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant James Herbert Green
(Address) 1030 Mc. McCulloh St.

15 Filed APR 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to April 8, 1923, that I last saw h[illegible] alive on April 8, 1923, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Primary

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) C. B. Anderson, M. D.

Apr 9 1923 (Address) 712 S. Bond Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 11 1923
20 UNDERTAKER	ADDRESS 322
Mrs. Kate R. Williams	E. Schroeder St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Use only one line for each cause. Do not use abbreviations or terms not generally understood. Do not report modes of dying, such as heart failure, asphyxia, anemia, or uremia, without assigning the disease causing these conditions. Indefinite or unsatisfactory causes of death will be returned for correction. Statements of contributory causes of death are desired. Operations should be reported only when performed for the cause of death. Maternal deaths should be reported as such. Violent deaths must be fully explained. Coroner's cases must be reported by the Coroner. Stillbirths should be reported. Deaths of infants under one year should be reported as to cause, age, and birthplace of parents. Deaths of females 15 to 50 years of age should be reported as to whether single, married, widowed, or divorced. Physicians are required to report the above facts to the Health Department. Prompt burial or removal permits will be issued upon receipt of certificates. See instructions on back of certificate. THIS SECTION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74677

CERTIFICATE OF DEATH.

51

D74677

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2029 N Saratoga St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Catherine Byrne

(a) Residence No. 2029 N Saratoga St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar 17, 1919

7-AGE. 4 yrs. mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town). Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, John J Byrne

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Lydia E King

13-BIRTHPLACE OF MOTHER (city or town). Balto (State or Country), Md

14- (Informant) John J Byrne
(Address) 2029 N Saratoga

15-

Filed..... 192.. ROBERT R. KRAUTER, Registrar.

APR 10 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 8, 1923

17- I HEREBY CERTIFY, That I attended deceased from February 22, 1923 to April 8, 1923 that I last saw h.. alive on ..., 1923 and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Acute Pericarditis

(Duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. D. Cockayne M. D.

4/9, 1923 (Address) 24 N Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cemetery	4/10, 1923
20-UNDERTAKER. J. J. Daly & Sons	ADDRESS 1315 Light St

In plain terms, so that it may be properly, instructions on back of certificates.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Acute Rheumatic Fever

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74678

CERTIFICATE OF DEATH.

74001 D74678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 Carrollton Ave ST., 18 WARD)

2-FULL NAME Carrie M Trible

(a) RESIDENCE NO. Carrollton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex County (State or country) Virginia

PARENTS

10 NAME OF FATHER Peter S. Trible

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy A Muse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Peter S Trible (Address) 330 N Carrollton Ave

15 APR 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 9, 1923, that I last saw her alive on ~~March~~ April 8, 1923, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 5 yrs. + mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? From usual clinical

(Signed) Bernard Powell Muse, M. D.

4/9, 1923 (Address) 1037 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lebanon Church Cem. Va

DATE OF BURIAL April 12, 1923

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

MAKE ENTRIES so that it may be properly classified. CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74679 — CERTIFICATE OF DEATH. — 179 D74679

1-PLACE OF DEATH Home for the Aged — REGISTERED NO. C.....

CITY OF BALTIMORE: (NO. 400 Fulton Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Harriett C. McFadden

(Residence in Baltimore: No. Home for Aged of the M. E Church St., 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, January (Month) 8 (Day), 1837 (Year)

7-AGE, 86 yrs. 3 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), Harford Co Maryland

PARENTS.

10-NAME OF FATHER, Charles Mc. Fadden

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Wiles

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Thaddeus Ady

(Address) 400 N. Fulton Ave.

15- APR 10 1923 ROBERT R. KRAUTER, Filed ....., 191..... Burial Permit Clerk.

CAUSE OF DEATH: Information in this column is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1923, to April 8 1923, that I saw her alive on April 8 1923, and that death occurred, on the date stated above, at 5:45 p. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

..... (Duration) 2 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Coma

..... (Duration) ~ yrs. ~ mos. 1 ds.

(Signed) George C. Shannon M. D.

Apr 9, 1923 (Address) 700 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Rock Burial Harford Co — DATE OF BURIAL, April 11, 1923

20-UNDERTAKER George J. Smith — ADDRESS 1531 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74680

CERTIFICATE OF DEATH.

D74680

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Womens Home ST., 19 WARD)

2-FULL NAME Alonzo C Newbell

(a) RESIDENCE No. 1400 W Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3, 1840

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John L Newbell

11 BIRTHPLACE OF FATHER (city or town) Snow Hill (State or country) Maryland

12 MAIDEN NAME OF MOTHER Christina Steven

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alice F Jones

(Address) 1400 Lexington Mason

15 APR 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl 5, 1923, to Apl 9, 1923, that I last saw h alive on Apl 8, 1923 and that death occurred, on the date stated above, at 6 40 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Woodward M. D.

April 9, 1923 (Address) 737 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL April 11, 1923

20 UNDERTAKER George J Smith ADDRESS 1532 Hallins

BEFORE FILLING OUT THIS CERTIFICATE, READ CAREFULLY THE INSTRUCTIONS GIVEN. Write so that it may be properly classified. Use only black ink. Do not use abbreviations or ditto marks. CAUSE OF DEATH in plain terms, so that it may be properly classified. Use only black ink. Do not use abbreviations or ditto marks. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00 D74681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Amity ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Evans

(a) RESIDENCE NO. 124 N. Amity ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Bertha Evans

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 78; Months; Days; If LESS than 1 day,.... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Junk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Dennis Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Fannie Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs Wm B Evans

(Address): 124 N Amity St

15 APR 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923. to April 7 1923.

That I last saw him alive on April 7, 1923.,

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos 12 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

(Address) 1520 Monument

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 4/10 1923

20 UNDERTAKER: Saml T Hegerty

ADDRESS 578 W Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D74682

HEALTH DEPARTMENT—CITY OF BALTIMORE

74001 D74682

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lilly Parker

(a) RESIDENCE NO. 15 E. Center St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

R 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1923

17

I HEREBY CERTIFY, That I attended deceased from October 19, 19 18 to April 6, 1923, that I last saw her alive on April 6, 1923, and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

4-10-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	19
20 UNDERTAKER Commissioner Health.	ADDRESS
P. p. WM. E. WOODALL.	APR 10 1923

CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74683

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah E. Williams

(a) Residence No. 536 Addison Alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1844

7-AGE. 78 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Florida

PARENTS.

10-NAME OF FATHER, Isaac Hickman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

11- (Informant) Municipal Hospital Record

(Address) UNIV

15- Filed ..., 19.. Robert P. Harrison, Registrar.

APR 10 1923 Burial Permit Clerk.

in plain terms, so that it may be properly ... instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 8, 1923 to April 7, 1923

that I last saw her alive on April 7, 1923

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. A. McKay M. D.

4-7-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19..
ERSITY OF MARYLAND	
20-UNDERTAKER.	ADDRESS
Commissioner Health.	APR 10 1923

Par. Wm. E. WOODALL.

Spec.—1-10-21—M&T—1500 Bks.

D74684

HEALTH DEPARTMENT—CITY OF BALTIMORE

80 D74684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 414 Glen Edward Av ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M Pollitta

(a) RESIDENCE NO. 414 Glen Edward Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7-1922

7 AGE — Years: — Months: 8 Days: 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Jessie Pollitta

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Gurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Mr Mary Pollitta

(Address) 414 Glen Edward Av

Robert F. Harrison,

Registrar

Burial Permit Clerk

R 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to April 9, 1923,

that I last saw h/r alive on April 9, 1923,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Teething Side

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L C Richardson M. D.

, 1923 (Address) 1120 W 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent DATE OF BURIAL: April 16 1923

20 UNDERTAKER: A S Marshall ADDRESS: 3513 Hall Rd

IMPORTANT WORDS must be written in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D74685 HEALTH DEPARTMENT—CITY OF BALTIMORE D74685

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Mercy Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon C. F. Crane.

(a) Residence No. 1212 Lindenave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) Sept. 19 1872

7-AGE. 50 yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town)... New York
(State or Country),

PARENTS.

10-NAME OF FATHER, William C. Crane

11-BIRTHPLACE OF FATHER (city or town)... Canada
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary La Fayette

13-BIRTHPLACE OF MOTHER (city or town)... New York
(State or Country),

11- (Informant)... Mrs. Crane

(Address) 1212 Lindenave

15- 10 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 11 1923

17- I HEREBY CERTIFY, That I attended deceased from April 2 1923 to Apr. 9 1923

that I last saw h[illegible] alive on Apr. 9 1923

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Dementia Praecox (?)

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia, Cardiac Failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. V. Brosnan M. D.

, 19 (Address) Mercy Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Apr 11 1923
20-UNDERTAKER	ADDRESS
Jones & Tomlson	12-14 N Green St

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74686 HEALTH DEPARTMENT—CITY OF BALTIMORE D74686

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2900 Keyworth Ave 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. O'Rourke

(a) RESIDENCE No. 2900 Keyworth Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luke O'Rourke

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. Y.
(State or country)

PARENTS

10 NAME OF FATHER John Hynes

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Celia O'Rourke

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mary C. O'Rourke
(Address) 2900 Keyworth Ave

15 Filed APR 10 1923, 19 Robert T. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to April 8, 1923, that I last saw h[illegible] alive on April 8, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

[illegible]

Two days under me care

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Emerson, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Apr 11 1923

20 UNDERTAKER Wm. Tickner & Sons ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

(Albert D. Klein)

D74687 HEALTH DEPARTMENT—CITY OF BALTIMORE D74687

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C 170

City of BALTIMORE: (No. 2705 Gilford ave St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME albert D Klein

(Residence in Baltimore: No. 2705 Gilford ave St.; yrs. 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: mail

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: Aug (Month) 24 (Day) 1862 (Year)

7-AGE: 61 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Heating
(b) General nature of industry, business, or establishment in which employed (or employer): Plumber

9-BIRTHPLACE, (State or Country): Richmond Va

PARENTS.

10-NAME OF FATHER: Henry Klein

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Augusta Horn

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) alvin H Klein

(Address) 2705 Gilford ave

Filed OCT 1 0 1923 19?

Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry) and other investigations, find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun shot wound through head Suicide

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos Morrison M. D.
(Coroner.)

Oct 6 1923 (Address) 1632 Roland

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
London Park Cem 19

20-UNDERTAKER, ADDRESS
H. Elbert Wishon 1018 Edmond

PR

Do not state CAUSE OF DEATH in plain terms, as "Stomach Trouble," "Kidney Disease," "Heart Failure," etc. This is very important. See instructions on back of certificate.

D74688 HEALTH DEPARTMENT—CITY OF BALTIMORE D74688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 Bevan Street. St., 23/85 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah R. Fisher.

(Residence in Baltimore: No. 911 Bevan Street. 79 --- 6 --- 22. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Widow.

6-DATE OF BIRTH. September 18, 1843. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
79 yrs. 6 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Grimes.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER, Susie Delahay.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Goldsborough. (daughter).

(Address) 911 Bevan Street.

15- Robert F. Harrison.

Filed ..... 192.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 9, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart & Kidneys.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Accidental fall down stairs.

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

192.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	April 11 1923
20-UNDERTAKER.	ADDRESS
William Cook	502 E North Ave

State CAUSE OF DEATH in plain English words. Statement is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74689

CERTIFICATE OF DEATH. D74689

1-PLACE OF DEATH University Hospital REGISTERED NO. 38

CITY OF BALTIMORE: (No. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Keene

(a) RESIDENCE NO. 2129 Huntingdon Ave ST. Baltimore WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4th 1923.

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Arthur Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elsie Culbertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mother.
(Address)

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1923

17

I HEREBY CERTIFY, That I attended deceased from , 19 , to April 10, 1923.

that I last saw h alive on April 10, 1923.

and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Following intravenous injection Neoarsenol.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. 2 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wasserman & Sonn.

(Signed) Harry M Robinson, M. D.

, 19 (Address) 405 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL April 11 1923

20 UNDERTAKER William Cook — ADDRESS 502 Park

10 1923

CAUSE OF DEATH in plain terms, so that it may be properly coded. Abbreviations should not be used. Do not write on back of certificates. See instructions on back of certificates. TION is very important.

D74690 HEALTH DEPARTMENT—CITY OF BALTIMORE D74690

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Bon Secours Hosp from 2703 E. Balto St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland Olson

(Residence in Baltimore: No. 4102 E. Balto St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
about ~~35~~ 38 or 39 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Escanaba Mich

PARENTS.

10-NAME OF FATHER: Peter Olson

11-BIRTHPLACE OF FATHER, (State or Country): Sweden

12-MAIDEN NAME OF MOTHER: Mary Peterson

13-BIRTHPLACE OF MOTHER, (State or Country): Sweden

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Olson

(Address) N. Balto.

15- Filed 192 Robert F. Harrison, Burial Permit Clerk, Registrar.

R 101923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 9 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Pulmonary

(Duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage, Sudden

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

April 192 3 (Address) 1637 Bay

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Escanaba Mich. 4/11/1923

20-UNDERTAKER. ADDRESS
E. J. Fanning & Son 1938 Lafayette Ave.

state CAUSE OF DEATH in plain terms, as this is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74691

58-001 D74691

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4502 Springdale Ave ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Bahr Lemmon

(Residence in Baltimore: No. 4502 Springdale Ave St.) 50 yrs., 8 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH. July 10, 1858.
(Month) (Day) (Year)

7-AGE. 64 yrs. 9 mos. 0 ds.

If LESS than 1 day. ....hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Madonna, Md

PARENTS.

10-NAME OF FATHER, Anthony Bahr

11-BIRTHPLACE OF FATHER (State or Country). Alsace Lorraine

12-MAIDEN NAME OF MOTHER Victoria ?

13-BIRTHPLACE OF MOTHER (State or Country). Alsace Lorraine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marian Lemmon Hildebrandt

(Address) 4502 Springdale Ave.

15-

10 1923 Robert P. Harrison, 191...

Burial Permit Clerk. Registrar.

CAUSE OF DEATH must be plainly written. Every question important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 9 (Day), 1923. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1923, to April 9 1923, that I saw her alive on April 9 1923, and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mildred C. Clough M. D.

Apr. 9, 1923 (Address) 24 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bethel Cemetery, Madonna Md. DATE OF BURIAL, 4/11/23, 191...

20-UNDERTAKER H E Hughes ADDRESS 4 nd N Broadway

Spec.—1-10-21—M&T—1500 Blks.

D74692

HEALTH DEPARTMENT—CITY OF BALTIMORE

108-001

D74692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Vincents Infant Asy.

CITY OF BALTIMORE: (No. 1401 division ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent McGreevy.

(a) RESIDENCE NO. 1401 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mgt Mc Greevy

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant St Vincents Inf. Asylum
(Address) Balto.

15 Filed APR 11 1923 19 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to April 9, 1923, that I last saw him alive on April 8, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. L. Goodborough Jr. M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick	April 10 1923
20 UNDERTAKER	ADDRESS
Mc. Mc Sherry & Sons Inc	1737 N Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Use no abbreviations or terms that may be misunderstood. Do not report symptoms, but the disease causing death. If the death was due to external violence, state the nature of injury and whether accidental, suicidal, or homicidal. If from any disease peculiar to women, state whether single, married, widowed, or divorced. If from any disease incident to childbirth, state whether before, during, or after labor. If from any disease peculiar to infants, state whether legitimate or illegitimate. If from any disease incident to occupation, state occupation and nature of business in which deceased was engaged. If from tuberculosis, state whether pulmonary or other form. If from cancer, tumor, or malignant disease, state whether reported to the Department of Health. If from typhoid fever, state whether reported by a physician or by the Widal test. If from any contagious disease, state whether reported to the Health Department. If from any disease reportable by law, state whether reported to the Health Department. If from any disease not reportable by law, state whether reported to the Health Department. If from any disease not reportable by law, state whether reported to the Health Department. If from any disease not

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

D74693

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74693

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 3605 Gwynnbrook (St.) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Letitia Amanda Millis

(a) RESIDENCE No. 3605 Gwynnbrook St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Wilbur Millis

6 DATE OF BIRTH (month, day, and year): May 21 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	80	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Israel Hook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Maria Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs Elmer G Bolton (Address) 3605 Gwynnbrook Ave

15 APR 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to April 9, 1923, that I last saw her alive on April 9, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Hypostatic congestion

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis - chron. Int. - nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~none~~

Did an operation precede death? ~~none~~ Date of

Was there an autopsy? ~~none~~

What test confirmed diagnosis? Pneumococcus Infection - loss of reflexes

(Signed) Wm F Keeley, M. D.

4/10, 1923 (Address) 3701 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: April 12 1923

20 UNDERTAKER: Henry Lutz — ADDRESS: N. Broadway

BEFORE AFFIXING SIGNATURE, be sure that you have answered each question. Data must be given for each item, or explanation offered why data cannot be obtained. CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or symbols. Indefinite statements are insufficient. Sign certificate in ink. Typewriting is preferable. Carefully read the certificate before signing. Every certificate must be complete and correct. See instructions on back of certificates. DATE OF DEATH is very important.

D74694 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D74694

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 E. Madison St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Crooks

(Residence in Baltimore: No. 921 E. Madison St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	colored	single

6-DATE OF BIRTH. April 10/23, 1..... (Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 6hrgs. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm. Crooks

11-BIRTHPLACE OF FATHER, (State or Country), British West Indies

12-MAIDEN NAME OF MOTHER, Annie Norris

13-BIRTHPLACE OF MOTHER, (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Crooks

(Address) 921 E. Madison

15- Filed APR 11 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10/23, 192..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes- Pribably Congental Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Haller M. D. (Coroner.)

4/10/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery — DATE OF BURIAL, Apr. 11 1923

20-UNDERTAKER, Chas. H. Johnson — ADDRESS 1469 N. Carlin St.

State CAUSE OF DEATH in plain terms, and fill in all items. It is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74695

CERTIFICATE OF DEATH.

179 D74695

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Miller

(a) RESIDENCE NO. Loraine Ave., Essex ST., WARD Essex

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 191

7 AGE	Years	Months	Days
	5	--	--

If LESS than 1 day, ... hrs. ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Damen Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt[illegible]re, [illegible]

12 MAIDEN NAME OF MOTHER Edit[illegible] ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Municipal Hospital Records.
(Address)

15 Filed APR 11 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 19 23

17 I HEREBY CERTIFY, That I attended deceased from April 9, 19 23, to April 9, 19 23, that I last saw her alive on April 9, 19 23, and that death occurred, on the date stated above, at 5:10 P.M.

The CAUSE OF DEATH* was as follows:

2nd degree burn over body, Trunk middle & thighs mp.

(duration) yrs. mos 9 hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. hrs.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) I. M. Shipley, M. D.

4-10-23 (Address) City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem. | DATE OF BURIAL April 12, 23

20 UNDERTAKER Geo M. Frick & Son | ADDRESS 5th & Penna

Notice should be properly classified. Each item must be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Coroner's Inq. Held April 10th 1923

D74696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1923 D74696

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard F. Underwood

(Residence in Baltimore: No. 1505 W. Fayette St; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: Married (Write the word.)

6-DATE OF BIRTH: March (Month) 10 (Day) 1884 (Year)

7-AGE: 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Broker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): W. Va.

PARENTS:

10-NAME OF FATHER: John Underwood

11-BIRTHPLACE OF FATHER, (State or Country): W. Va.

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country): U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H. F. Underwood

(Address) 1505 W. Fayette St

15-

Filed APR 11 1923 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 8 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage due to Pneumonoid

(Duration) since 3-4-23 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bullet wound is probably done from gunshot

(Duration) yrs. mos. ds.

(Signed) H. R. Jarrad M. D.
(Coroner.)

4-11 1923 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	April 12, 1923

20-UNDERTAKER.	ADDRESS
John J. Fields	1200 W. Fayette

state CAUSE OF DEATH in plain English. Do not use abbreviations or initials. Every statement is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74607

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 D74697

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor STREET 10 WARD)

2-FULL NAME Josephine Mills.

(a) RESIDENCE No. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8 Nov. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James B. Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Sister Florence, (Address) Little Sisters of the Poor

15 APR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17 I HEREBY CERTIFY, That I attended deceased from No record, 19 . to , 19 .

that I last saw h alive on April 8, 1923,

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cystitis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile dementia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Apl 10, 1923 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St Peters — DATE OF BURIAL April 12 1923

20 UNDERTAKER John J Fields — ADDRESS 1200 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74698

1923
40
1883

CERTIFICATE OF DEATH.

12 002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Maddox.

(a) RESIDENCE NO. 911 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gabriel B Maddox

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savannah Ga

PARENTS

10 NAME OF FATHER Cook Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Sophia Woodle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant G B Maddox

(Address) 911 Druid Hill Ave

15 Filed APR 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1923, to April 9, 1923, that I last saw her alive on April 9, 1923, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophic Cerebral Kidney

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Antoni Kaminowski M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL April 11 1923

20 UNDERTAKER Forrest E Wyth

ADDRESS 1864 W Cary

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74699 HEALTH DEPARTMENT—CITY OF BALTIMORE D74699

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 Wilhelm St. 20th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Gehard Landwher

(a) RESIDENCE. No. 1933 Wilhelm St. 20th Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Landwher

6 DATE OF BIRTH (month, day, and year) June 22-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	53	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Gehard Landwher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) German

12 MAIDEN NAME OF MOTHER Mary Kelling

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mary E. Landwher
(Address) 1933 Wilhelm St.

15 Filed APR 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/3, 1923, to 4/9, 1923, that I last saw h.. alive on 4/8, 1923, and that death occurred, on the date stated above, at 9:50 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 4 mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Cyril Ely, M. D.

, 19 (Address) 2530 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL April 19 23

20 UNDERTAKER F. B. Tippett ADDRESS 2136 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74700 HEALTH DEPARTMENT—CITY OF BALTIMORE D74700

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 E. Fairmount St. Av. 6 WARD)

2-FULL NAME Sophia Schocket

(a) RESIDENCE NO. 2123 E Fairmount ST. Av. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. (15 about) ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Patrsan, Md.

PARENTS

10 NAME OF FATHER Bzw Schocket

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Base

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) I. Hayre 1439 E. Baltimore St.

15 APR 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 29 , 1923 , to Apr. 10 , 1923 .

that I last saw her alive on Apr 10 , 1923 ,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

acute Pulmonary Oedema

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis + Myocarditis Heart about 6 mos Bronchopneumonia 6 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St Mary's C

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) A. F. Ris, M. D.

Apr 10 , 1923 (Address) 24 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Rosedale

DATE OF BURIAL April 11 1923

20 UNDERTAKER Jacob Lewis

ADDRESS 1439 E Balto

IMPORTANT—CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT information is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74701

CERTIFICATE OF DEATH.

90 D74701

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 W. Lombard ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Karschner

(Residence in Baltimore: No. 900 W. Lombard St.; 3 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1860 (Year)

7-AGE, 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, John Love

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Margaret Horland

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer Karschner

(Address) 900 W. Lombard St.

15- .....

Filed APR 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CAUSE OF DEATH must be plainly stated. Every question must be answered if possible. Physician should write plainly and use no abbreviations. Every item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1923, to April 9 1923, that I saw her alive on April 8 1923, and that death occurred, on the date stated above, at 11 H m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry H Weinberger M. D.

April 10, 1923 (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery

DATE OF BURIAL, Apr. 11, 1923

20-UNDERTAKER John J. Coyne & Son

ADDRESS 901 Hollins St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74702

CERTIFICATE OF DEATH.

101-001 D74702

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Berry ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Louisa Shauck

(a) RESIDENCE NO. 802 Berry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator on

(b) General nature of industry, business, or establishment in which employed (or employer) Machine

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER John H Shauck Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John H Shauck Jr 802 Berry St

15 APR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 14* 1923 to Apr 10 1923,

that I last saw h[illegible] alive on Apr. 9* 1923,

and that death occurred, on the date stated above, at 202a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Stroke of Cerebral Hemorrhage

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

11, 1923 (Address) 846 W 36 St —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middletown Balto Co	Apl 12 1923
20 UNDERTAKER	ADDRESS
Ehrenwerth & Son	Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. Local terms may be used in addition, but not instead of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74703

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Jackson

(a) RESIDENCE NO. 1148 N. Vincent st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dan Jackson

6 DATE OF BIRTH (month, day, and year) 1877 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M. C. H.

15 FILED APR 11 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1923, to April 8, 1923,

that I last saw her alive on April 8, 1923,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Francis L. Dalyhuren M. D.

4-8-23 (Address) Munic[illegible]pal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	4-11 1923
20 UNDERTAKER	ADDRESS
A. L. Parham	220 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite terms, such as "Heart Failure," "Old Age," "Senility," "Exhaustion," "Convulsions," "Paralysis," "Uremia," "Blood Poisoning," "Septicemia," "Pyemia," "Abscess," "Tumor," "Cancer," "Consumption," "Tuberculosis," "Meningitis," "Pneumonia," "Bronchitis," "Pleurisy," "Hemorrhage," "Hemorrhage of the Brain," "Apoplexy," "Cerebral Hemorrhage," "Cerebral Embolism," "Cerebral Thrombosis," "Cerebral Softening," "Cerebral Congestion," "Cerebral Abscess," "Cerebral Tumor," "Cerebral Meningitis," "Cerebral Paralysis," "Cerebral Convulsions," "Cerebral Uremia," "Cerebral Blood Poisoning," "Cerebral Septicemia," "Cerebral Pyemia," "Cerebral Abscess," "Cerebral Tumor," "Cerebral Cancer," "Cerebral Consumption," "Cerebral Tuberculosis," "Cerebral Meningitis," "Cerebral Pneumonia," "Cerebral Bronchitis," "Cerebral Pleurisy," "Cerebral Hemorrhage," "Cerebral Hemorrhage of the Brain," "Cerebral Apoplexy

Spec.—1-10-21—M&T—1500 Blks.

D74704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74704

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Maxwell

(a) RESIDENCE No. Hebrew Hospital E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-8-23

7 AGE — Years | Months | Days: 1½ | If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Harry C Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lena Schroeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Harry C Maxwell

(Address): 2218 Mura st

15 Filed APR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-8, 1923, to 4-10, 1923, that I last saw him alive on 4-10, 1923 and that death occurred, on the date stated above, at 4⁰⁰ P m.

The CAUSE OF DEATH* was as follows:

asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. atelectasis

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exam of Lungs

(Signed) Ernest Edlavitch M. D.

4-10, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: April 11th 1923

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

mation should be correctly supplied. Exact statement of facts CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74705

CERTIFICATE OF DEATH.

38 D74705

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Y. Eden ST.: 5 WARD)

2-FULL NAME Frank Taylor Goddard

(a) RESIDENCE. No. 609 Y. Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Mary Goddard

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or . min.
	33	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caulker 015

(b) General nature of industry, business, or establishment in which employed (or employer) Caulking Ships

(c) Name of employer Bethlehem Ship Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Julius Goddard

11 BIRTHPLACE OF FATHER (city or town) (State or country) English W. Indies

12 MAIDEN NAME OF MOTHER Carolina Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Thomas D. Taylor
(Address) 609 Y. Eden St.

15 Filed APR 11 1923, 19 ROBERT N. INGLIS, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1923 to April 9th. 1923 that I last saw him alive on April 8th. 1923 and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency
(b) Pulmonary Congestion about a year

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion about 24 hrs

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Murray Field Boyle M. D.

(Address) 4114 Cardenas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetary	April 12 1923

20 UNDERTAKER	ADDRESS
Joseph T. H. Rochester	1473 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact name of disease, not mode of dying, must be given. Indefinite terms, such as "Heart Failure," "Exhaustion," "Old Age," "Infirmity," "Senility," "Convulsions," "Paralysis," "Uremia," "Septicemia," "Pyemia," "Blood Poisoning," "Cancer," "Tumor," "Abscess," "Childbirth," "Miscarriage," "Abortion," "Still-born," "Premature Birth," "Suffocation," "Drowning," "Fracture," "Injuries," "Accident," "Homicide," "Suicide," "Found Dead," "Unknown," are not sufficient. If from violence, state the MEANS and NATURE of INJURY, as "Fall from Window," "Railway Injuries," "Gunshot Wound of Head," "Crushed by Falling Wall," "Burned in Factory," "Scalded by Steam," "Poisoned by Laudanum," "Hanging," "Strangulation," "Gas Asphyxia," "Drowned in Bay," "Shot by Police," "Run over by Car," "Kicked by Horse," "Burned in Conflagration," "Crushed in Collision," "Fell Down Stairs," "Poisoned by Carbolic Acid," "Poisoned by Bichloride of Mercury," "Poisoned by Morphine," "Poisoned by Illuminating Gas," "Asphyxia by Illuminating Gas," "Asphyxia by Strangulation," "Asphyxia by Suffocation," "Asphyxia by Drowning," "Shot by Self," "Shot by Other Person," "Stabbed by Other Person," "Fracture of Skull," "Crushing Injuries of Chest," "Stabbing of Heart," "Rupture of Liver," "Shock," "Hemorrhage," "Internal Hemorrhage," "Traumatic Pneumonia," "Traumatic Meningitis," "Traumatic Peritonitis," "Traumatic Shock," "Traumatic Hemorrhage," "Traumatic Septicemia," "Traumatic Pyemia," "Traumatic Tetanus," "Traumatic Gangrene," "Traumatic Erysipelas," "Traumatic Apoplexy," "Traumatic Cerebritis," "Traumatic Cerebral Hemorrhage," "Traumatic Cerebral Embolism," "Traumatic Cerebral Softening," "Traumatic Cerebral Abscess," "Traumatic Cerebral Thrombos

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74706

CERTIFICATE OF DEATH.

128 D74706

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Coulson

(a) Residence No. 1521 Kensett St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ L. M. ? Coulson

6-DATE OF BIRTH (month, day and year) Sept 23, 1898

7-AGE.	If LESS than 1 day,
24 yrs. mns. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, William Coulson

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed APR 11 1923 19.. ROBERT R. KRAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 10, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 26, 19 23 to April 10 19 23.

that I last saw him alive on April 9 19 23.

and that death occurred, on the date stated above, at 12:30 A. M.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death*

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKof M. D.

4-10-, 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lorraine Cemetery	Apr 11 1923

20-UNDERTAKER, Wm Cook for E Monahan — ADDRESS

In plain terms, so that it may be properly classified. See instructions on back of certificates.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No other abnormal Condition

Spec.—1-10-21—M&T—1500 Blks.

D74707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D74707

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 30 WARD)

2-FULL NAME Gilbert Meyers

(a) RESIDENCE No. 511 Norton Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Meyers

6 DATE OF BIRTH (month, day, and year) Nov. 22 1859

7 AGE 63 Years 4 Months 19 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Nathan Meyers

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Stern

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Jennie Meyers
(Address) 511 Norton Ave

15 Filed APR 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 9, 1923, to April 10, 1923, that I last saw him alive on April 10, 1923, and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 3 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B Jowett, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Benship	April 12 1923
20 UNDERTAKER	ADDRESS
Jahrens & Co	1611 Mad

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Myocarditis —
Arteriosclerosis.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74708

CERTIFICATE OF DEATH.

101-00

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1434 Vincent ST.: 15 WARD)

2-FULL NAME Dora Margaret Louise Adams Matthews

(a) RESIDENCE. NO. 1434 Vincent ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Matthews

6 DATE OF BIRTH (month, day, and year) Not known-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Matthews. (Address) 1434 Vincent

15 Filed APR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 8 19 23

17 I HEREBY CERTIFY, That I attended deceased from Apr. 4 19 23 to Apr. 8 19 23, that I last saw h r alive on Apr. 8 19 23, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination. Clinical

(Signed) ..... M. D.

, 19 (Address) 1434 Vincent

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 11 1923
20 UNDERTAKER James H. Deems	ADDRESS 202 Presstman

MARGIN SHOULD BE KEPT CLEAR FOR BINDING. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D74709

CERTIFICATE OF DEATH.

#6

D74709

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 E. Henrietta St ST., 22 WARD)

2-FULL NAME Elizabeth Nash

(a) RESIDENCE No. 26 E. Henrietta St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 01 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Geo H Gosnell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mary Fox

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Geo H Gosnell (Address) 26 E. Henrietta

15 Filed APR 1 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10-1923

17

I HEREBY CERTIFY, That I attended deceased from March 27. 1923. to April 10-1923.

that I last saw her alive on April 9-, 1923

and that death occurred, on the date stated above, at 5.20 A.m.

The CAUSE OF DEATH* was as follows:

apoplexy

Carcinoma of Uterus +

Gangrene (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus + Gangrene (duration) 1 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr GW Kennard M. D.

4-10. 1923 (Address) 708 Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL April 12 1923

20 UNDERTAKER Schaefer & Fields

ADDRESS 1100 W Fayette

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D74710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74710

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Forest ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel J. Lucey

(a) RESIDENCE NO. 717 Forrest ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Mary A. Lucey

6 DATE OF BIRTH (month, day, and year) Aug 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Lucey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary A Lucey

(Address) 717 Forrest St

15 APR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) April 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27nd, 1923, to April 2nd, 1923, that I last saw him alive on April 2nd, 1923, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) John J. Chapman M. D.

, 19 (Address) 516 Hollins Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL April 12 1923

20 UNDERTAKER H. C. Wisdefeld — ADDRESS 9x Fremont Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

Horner.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D74711

D74711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Lessier ST. 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A. Homier

(a) RESIDENCE NO. 815 Lessier ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Homier

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lilythmans Neck Md

PARENTS

10 NAME OF FATHER Henry Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles H. Homier

(Address) 815 Lessier St

15 APR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8th 1923, to April 9th 1923, that I last saw h— alive on April 8th 1923, and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1200 E.T.V. Co

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D. Lee Ellis, M. D.

4/10. 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4/11 1923
20 UNDERTAKER Samuel Hemsley	ADDRESS 1128 Bdle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D74712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 S. East ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Haupt

(a) RESIDENCE NO. 1010 S. East ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Haupt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Millhahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) James Haupt 1010 S. East Ave

15 APR 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1923

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1923, to April 10, 1923, that I last saw him alive on April 9, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Mes Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace J. Tilson M. D.

4/10, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	April 12 19 23
20 UNDERTAKER Zurkler & Zirkler	ADDRESS 739 Eaton

CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74713 HEALTH DEPARTMENT—CITY OF BALTIMORE D74713

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dorsey

(a) Residence No. Abbotton Md St.; Ward Abbottown Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 13 1923

7-AGE, ...yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Albert Dorsey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Geneva Bradley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hosp Records

(Address)

15- Filed 1923 Robert P. HARTSOCK, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-11-23

17- I HEREBY CERTIFY, That I attended deceased from April 7 1923 to April 11 1923

that I last saw h[illegible] alive on April 11 1923

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carbuncle Neck

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sym. & Signs

(Signed) H. J. Scroggs M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF INTERMENT OR REMOVAL Howard Co Freetown Cem

DATE OF BURIAL, Apl 13 1923

20-UNDERTAKER Easton Sons

ADDRESS Ellicott City Md.

In plain terms, so that it may be properly classified. See instructions on back of certificates.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Primary

D74714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74714

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Garnet Follmer

(Residence in Baltimore: No. 910 St Paul St.; yrs. 52 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. November (Month) 14 (Day) 1870 (Year)

7-AGE. 52 yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bridgie Follmer

(Address) 910 St. Paul Street

15- Robert P. Harrison,

Filed ..... 192.... Burial Permit Clerk. Registrar.

11 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apl (Month) 10 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Adenoma of Cardiac Lung

Acute Dilatation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hy. No Stat, & Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

Apl 10 1923 (Address) 1659 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	4/12 1923

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. This is very important.

Spec.—1-10-21—M&T—1500 Bks.

D74715

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74715

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Jane Phipps.

(a) RESIDENCE NO. 1552 Carswell Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Rank Phipps

6 DATE OF BIRTH (month, day, and year) Oct 27, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Shirt factory

(c) Name of employer Wm Bros - 86

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harry C. Cartwright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Barrow in Furnace, England

12 MAIDEN NAME OF MOTHER Cynthia E. Wickwire

13 BIRTHPLACE OF MOTHER (city or town) Troy (State or country) New York.

14 Informant Mrs. Hattie Shaw

(Address) 709 William St. Baltimore, Md.

15 1904 Robert P. Harrison, Registrar

R 1 11929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1928

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1923, to April 11, 1923, that I last saw her alive on April 10, 1923, and that death occurred, on the date stated above, at 2.55 A m.

The CAUSE OF DEATH* was as follows:

Perinephritic abscess

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None - Autopsy

(Signed) Norman C. Tannenbaum M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 13 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Fayette

mation should be properly classified. Each
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Blks.

D74716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74716

CERTIFICATE OF DEATH.

X 38

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Marshall

(a) RESIDENCE NO. La Plata, Md. ST., WARD La Plata Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prince Georges Co Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. R. H. Marshall

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eleanor Marshall

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Records
(Address)

15 ....., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1923

17

I HEREBY CERTIFY, That I attended deceased from 1/8, 1923, to 4/10, 1923,

that I last saw him alive on 4/10, 1923,

and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Tabes Dorsalis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & clinical findings

(Signed) Leon Friedman M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Waldorf, Charles Co, Md — DATE OF BURIAL: Apr 11 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 152 W. Lombard

Buried Forest Glade Robert E. Jefferson

R 1 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT SPELLING TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74717 ✓ D74717

D74717

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 937 N. Chapel ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reinhard May.

(a) RESIDENCE NO. 937 N. Chapel. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 9 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Mathis.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry May.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Rosa Krebs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles May (Address) 937 Chapel St

15 Robert P. Harrison, Registrar

1 1 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14 1923 to 4-8 1923

that I last saw him alive on 4-8 1923

and that death occurred, on the date stated above, at 12.46 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tenderness

(Signed) Fred Bryerly, M. D.

1923 (Address) 700 N Patt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sparrows Cemetery. DATE OF BURIAL April 12 1923

20 UNDERTAKER Geo. L. Ruth ADDRESS 1735 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information TION is very important. See instructions on back of certificates.

D74718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74718

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Body found off Quarantine St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Frederick J. Schultz.....

(Residence in Baltimore: No. 1519 Beason St. St.; yrs. 24 mos. 10 ds. 29)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. March 23rd. 1898. (Month) (Day) (Year)

7-AGE. 24 yrs. 10 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Mess Boy.
(b) General nature of industry, business, or establishment in which employed (or employer)..... S/S Hatteras.

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. William R. Schultz.

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Ida Suter.

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William R. Schultz, (father)

(Address) 1519 Beason St.

15-

Filed..... Robert P. Harrison, Registrar.

R 1 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Missing Feb, 21, 1923. Body found April 10th. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

April 11 1923 (Address) 1217 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Old Lawn	April 12th 1923
20-UNDERTAKER. Phillips & Sturey	ADDRESS 2016 Albans Av

State CAUSE OF DEATH in plain terms, so that it may be understood. It is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74719

1-PLACE OF DEATH South Baltimore Gen. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 1911 Light St., ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bertha Johnson.

(a) RESIDENCE NO. 1611 Harrison Alley. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female. 4 COLOR OR RACE: White. 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Leonard Johnson.

6 DATE OF BIRTH (month, day, and year): Aug. 18 - 1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Kayser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore.

12 MAIDEN NAME OF MOTHER: Annie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore.

14 Informant: Husband.

(Address) Leonard Johnson 1611 Harrison Alley

15 Filed APR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/11/1923

17 I HEREBY CERTIFY, That I attended deceased from 4/7/1923 to 4/11/23, that I last saw h alive on 4/11/23, and that death occurred, on the date stated above, at 2:50 A. m.

The CAUSE OF DEATH was as follows:

Uremia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Nephritis.

(duration) yrs. 2, mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Chemical tests

What test confirmed diagnosis?

(Signed) John A O'Connor, M. D.

(Address) South Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: 4/14 1923

20 UNDERTAKER: L. Frew McCully

ADDRESS: 130 E. Fort

mation should be carefully written in ink, so that it may be properly classified. Exact information is required in every case. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required in every case. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74720 ✓ D74720

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1732 N. Gay ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME June Constance Caldwell

(a) RESIDENCE. No. 1732 N. Gay. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Guy Caldwell

11 BIRTHPLACE OF FATHER (city or town) Brampain
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Adria Ellison

13 BIRTHPLACE OF MOTHER (city or town) Clinton Co.
(State or country) Pa.

14 Informant Adria E. Caldwell
(Address) 1732 N. Gay St.

15 Filed APR 12 1923 19... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10- 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-9- , 1923, to 4-10- , 1923, that I last saw her alive on 4-10- , 1923, and (that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ileocolitis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland., M. D.

4-10, 1923 (Address) 2532 Edmondson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	April 12th 1923
20 UNDERTAKER	ADDRESS
Leo G. Cook	Northbedford

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D74721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74721

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Race street ST.; 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Smith

(a) RESIDENCE. NO. 1105 Race ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

11 Informant Annie Wilson

(Address) 1105 Race St.

13 APR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/1923

17 I HEREBY CERTIFY, That I attended deceased from 4/6/1923, to 4/10/1923, that I last saw h... alive on 4/10/1923 and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lincoln Cole M. D.

4/11/1923 (Address) 908 S. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	April 14 1923

20 UNDERTAKER C. L. Brown & Son ADDRESS 1010 Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D74722 HEALTH DEPARTMENT—CITY OF BALTIMORE D74722

CERTIFICATE OF DEATH.

80

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 800 Hanover ST 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Dorsey

(Residence in Baltimore: No. 800 Hanover St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	

6-DATE OF BIRTH. May 27, 1922 (Month) (Day) (Year)

7-AGE. 1 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Robert Dorsey

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Lena Shanklin

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Dorsey

(Address) 800 Hanover st

15-

Filed APR 12 1923 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr. 10, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 8 1923, to Apr. 10 1923, that I saw h.. alive on Apr 9 1923, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) ...yrs. ...mos. ...ds.

(Signed) H. Krauter M. D.

Apr 10, 1923 (Address) 1300 Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	April 12, 1923
20-UNDERTAKER	ADDRESS
S. R. Brown's Son	707 N. Monroe

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74723 D74723

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 N. Bond ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Kimball Gordon

(a) RESIDENCE NO. 1307 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1st 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Gordon

11 BIRTHPLACE OF FATHER (city or town) Boston (State or country) Mass

12 MAIDEN NAME OF MOTHER Ellen Kimball

13 BIRTHPLACE OF MOTHER (city or town) Lowell (State or country) Mass

14 Informant Mrs Edith Gordon (Address) 1307 N Bond st

15 Filed ..... 19 ..... Registrar

APR 12 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11. 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch. 26. 1923, to April 11. 1923, that I last saw her alive on " 10. 1923, and that death occurred, on the date stated above, at 8.50 a.m.

The CAUSE OF DEATH* was as follows:

La Grippe Bronchitis

3 days

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy left hemiplegia

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

1923 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 13th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1116 E Monument st

mation should be carefully supplied. Exact statement of disease may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74724

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-002

D74724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 3341 Windsor ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert B. Seidenstricker

(a) Residence No. 3341 Windsor Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edith D. Seidenstricker

6-DATE OF BIRTH (month, day and year) May 13 1868

7-AGE, 54 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Accountant

(b) General nature of Industry, business, or establishment in which employed (or employer)..... B.O. R.R.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Albert B. Seidenstricker

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Harriet B. Davis

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country), Md.

14- (Informant) Edith D. Seidenstricker

(Address) 3341 Windsor ave

15-

Filed APR 12 1923 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

in plain terms, so that it may be properly classified. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 10/23

17- I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to April 10, 1923, that I last saw him alive on April 10, 1923, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease 2 years

Influenza.

(Duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Blood Count P.E.

(Signed) John E. Bishop, M. D.

, 19 (Address) 720 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park DATE OF BURIAL, Apr. 13, 1923

20-UNDERTAKER, John Ourtehell ADDRESS 120 W. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

(Yaker)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74725

CERTIFICATE OF DEATH.

100-00 D74725

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital & Asylum ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Yaker

(a) RESIDENCE NO. 814 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Shia Yaker

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto St

15 APR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-1923

17 I HEREBY CERTIFY, That I attended deceased from March 24 1923 to April 11 1923.

that I last saw her alive on April 11 1923

and that death occurred, on the date stated above, at 4.15 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation, due Coronary thrombosis

(duration) yrs. 2 wks mos. da.

CONTRIBUTORY (Secondary) Bronchial pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Leonard A. Greenbaum M.D.

, 19 (Address) Hebrew Hospital Va.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrens Rosedale

DATE OF BURIAL 4/12 1923

20 UNDERTAKER Jack Lewis 1439 E Balto Street

ADDRESS

mation should be carefully supplied. Any information that it may be properly classified. EXACT statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D74726 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74726

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hosp. St., 5 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rae Bella Goedberg

(a) RESIDENCE NO. 1113 Orleans St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	M

5a If married, widowed, or divorced (a) ~~HUSBAND of~~ WIFE of Jacob Goldberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Bogatsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Brown

(Address) 319 N. Townsend St

15 Filed APR 12 1923 ROBERT R. KRAUTER, Registrar

~~Burial Permit Issued~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to Apr 12, 1923, that I last saw her alive on apr. 6, 1923, and that death occurred, on the date stated above, at 4.05a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema Cardiac Dilatation

(duration) yrs. mos. 2 hrs

18 Where was disease contracted, if not at place of death? 1116 Orleans St

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Moses Jaulson, M. D.

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Friendship	April 12 1923
20 UNDERTAKER	ADDRESS
Jack Levin.	1439 E Baltimore

mailed promptly to Registrar. EXACT statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

pec—12-23-21—E.B.R.S.—400 Bks.

D74727 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D74727

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 533 S Chapel St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kruszynski

(a) Residence No. 533 S. Chapel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Casimier Kruszynski

6-DATE OF BIRTH (month, day and year) April 1 1864

7-AGE. 59 yrs. mos. 9 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House work

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Casimier Kruszynski (Address) 533 S Chapel St

15- Filed APR 12 1923 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 10 1923

17- I HEREBY CERTIFY, That I attended deceased from March 20, 1923 to April 10, 1923

that I last saw h. alive on April 10, 1923

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Kyser M. D.

April 11, 1923 (Address) 801 E 16 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary — DATE OF BURIAL. April 13 1923

20-UNDERTAKER. John M Weber — ADDRESS 1803 Bank St

in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Barr.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D74728

CERTIFICATE OF DEATH.

74-001 D74728

1-PLACE OF DEATH 808 Park ave

CITY OF BALTIMORE, (No. Eliza Cresswell Barr ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Cresswell Barr

(a) RESIDENCE NO. 808 Park ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ ~~late~~) WIFE of Rev. John Campbell Barr

6 DATE OF BIRTH (month, day, and year) May 16, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83 years	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) Alexandria (State or country) Huntingdon Co., Penna.

PARENTS

10 NAME OF FATHER Nicholas Cresswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Clearfield Co., Penna

12 MAIDEN NAME OF MOTHER Mary Ann Kennell

13 BIRTHPLACE OF MOTHER (city or town) Alexandria (State or country) Huntingdon Co., Penna.

14 Informant Alfred N. Barr.

(Address) 909 Park Ave., Baltimore, Md.

Filed APR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1922, to Apr 11, 1923, that I last saw h ~~e~~alive on Apr 10, 1923, and that death occurred, on the date stated above, at 10.50 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

with hemiplegia

(duration) — yrs. 6 mos. 15 ds.

CONTRIBUTORY (Secondary) Advanced age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam.

(Signed) Chas. J. Keller, M. D.

April, 1923 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Petersburg Huntingdon Co Penna	April 13 1923

20 UNDERTAKER John B. Spence ADDRESS 1325 N. Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74729

CERTIFICATE OF DEATH.

101-001 D74729

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 Esther Place ST. No WARD)

2-FULL NAME Clifford H. Payne

(a) RESIDENCE. No. #3407 Esther Pl. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Edna E. Payne

6 DATE OF BIRTH (month, day, and year) May 3rd 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Canton Box Fact.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Summerset Co. Md.

PARENTS

10 NAME OF FATHER John Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Edna Payne
(Address) 3427 Esther St.

15 FEB 1 2 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1923

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1923, to April 10, 1923, that I last saw him alive on April 10, 1923, and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency Edema Lungs yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Geyer M. D.

. 19 (Address) # 541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	April 13 1923

20 UNDERTAKER Wendell Dippold & Son ADDRESS 37 S. Amm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Janneo

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D74730

D74730

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE (No. ..... ST., 3 WARD)

2-FULL NAME Dominick Janneo. alias Harry Phillips

(a) RESIDENCE NO. 904 Town ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 32 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Italy Portugal

PARENTS

10 NAME OF FATHER John Janneo Do

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Boy View Hospital (Address) Baltimore, Md.

15 Filed APR 12 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to April 10, 1923

that I last saw him alive on April 10, 1923

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lentic Carpenter

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes Clinical & Serological findings

What test confirmed diagnosis? .....

(Signed) N. Fedowitz, M. D.

4/11/1923 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apl 13 1923
20 UNDERTAKER	ADDRESS
Mundell Doppel & Son	378 Pr

mation should be carefully supplied. Exact statement of facts
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74731

CERTIFICATE OF DEATH.

D74731
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Home Catholic St. Lexington Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Captain Joseph Kershaw

(a) Residence No. Aged Home Catholic St., Lexington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

5-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ? ? ?

7-AGE, about	If LESS than 1 day,
78 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work unknown

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Agnes Healy

(Address) 420 Lorraine Ave.

15- Filed APR 12 1923 ROBERT R. KRAUTER, Register.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 10 - 23

17- I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Apl 10, 1923, that I last saw h... alive on April 7/23, 1923, and that death occurred, on the date stated above, at 2.15 a m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Arrowood M. D.

Apl 11 1923 (Address) 739 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Mt Carmel Cemetery	April 14 1923
20-UNDERTAKER,	ADDRESS
William Cook	501 E North

In plain terms, so that it may be properly classified. Exact statements of instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74732

CERTIFICATE OF DEATH.

X 188-603

D74732

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Irene Francis

(Residence in Baltimore: No. Middle River Maryland St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 13 (Day), 1918 (Year)

7-AGE, 4 yrs. 10 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Howard Francis

11-BIRTHPLACE OF FATHER (State or Country) Harford Co Md

12-MAIDEN NAME OF MOTHER Louise Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Francis

(Address) Middle River Md

15- Filed APR 12 1923, 191 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 11 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull — Struck by Auto Truck

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. S. H. Pollitt M. D. (Coroner.)

4/12/23 (Address) 502 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Middle River Md

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemtery

DATE OF BURIAL, April 13 1923

20-UNDERTAKER William Cook

ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74733

CERTIFICATE OF DEATH.

100-001 D74733

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Pearce

(a) RESIDENCE NO. 1711 Orleans St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) [redacted] 1867

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs or ..... min.
	55	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed APR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1923

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1923, to April 10, 1923, that I last saw her alive on April 10, 1923, and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McCoy, M. D.

4-11-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — DATE OF BURIAL 13 April 1923

20 UNDERTAKER Edward Bryon — ADDRESS 631 Orleans St

mation should be carefully supplied. Each statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Ilks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74734 D74734

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Anderson

(Residence in Baltimore: No. 1535 Orleans St.; Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ? (Month) ? (Day) 1877. (Year)

7-AGE, 46 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Anderson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Jane Boston

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kemp (Cousin)

(Address) 173 W. Saratoga St

15-

Filed APR 12 1923 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 9 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 3 1923, to April 9 1923, that I saw h im alive on April 5 1923, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver

(Duration) ..yrs. ..mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis Senility

as Arteriosclerosis (Duration) ..yrs. ..mos. ..ds.

(Signed) R. F. Young M. D.

4/11, 1923 (Address) 1429 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery	April, 1923
20-UNDERTAKER	ADDRESS 631
Edward Bryan	Orleans St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74735

D74735

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 4227 A. Donnell St., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Le Brun

(a) RESIDENCE NO. 4224 A. Donnell St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary M. Le Brun

6 DATE OF BIRTH (month, day, and year) Nov 5-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Le. Brun

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Mary J. Market.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mr Robt Krauter (Address) 4227 A Donnell St

15 APR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 5. 1922, to April 10. 1923, that I last saw him alive on April 9. 1923, and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 4 mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D.W. Jewell, M. D.

4/11. 1923 (Address) 1011 O. Edmondson ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL April 13 1923

20 UNDERTAKER John Ellicks

ADDRESS 2008 E. Lexington

mation should be carefully supplied. Exact statement of occupation CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74736

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 Scott ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace C. Grempler

(a) RESIDENCE. NO. 517 Scott ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward A. Grempler

6 DATE OF BIRTH (month, day, and year) Mar 21 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob C Deems

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anarebecca Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Edgar J. Grempler (Address) 517 Scott St.

15 FILED APR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11th 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1922, to April 11th 1923, that I last saw h alive on April 10th 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 3 mos. + ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Blood Analysis

(Signed) Walter E. Grempler, M. D.

. 19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	April 15 1923

20 UNDERTAKER Nelson E. Stiles — ADDRESS 320 Md. Ave. Westport

MAKE STATEMENTS OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1506 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74737

CERTIFICATE OF DEATH.

90 ✓ D74737

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 S. Bond St., 3 WARD)

2-FULL NAME Blanna Paymer

(a) RESIDENCE NO. 42 S. Bond St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 28 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Paymer

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Perkind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Lewis
(Address) 1439 E. Baltimore St.

15 APR 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1923, to Apr. 11, 1923,
that I last saw h[illegible] alive on Apr. 11, 1923,
and that death occurred, on the date stated above, at 3 9 m.
The CAUSE OF DEATH* was as follows:

Myocarditis ?

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. T. Reis, M. D.

April 12 1923 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Jewish Cem. DATE OF BURIAL April 12 1923

20 UNDERTAKER Jack Lewis, ADDRESS 1439 E. Balto

mation should be carefully supplied. Exact statement of OCCUPA
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions o
ons on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74738

CERTIFICATE OF DEATH Lake Drive 101-00 D74738

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Alhambra Apts. ST.: 127 WARD)

2-FULL NAME Moses Moses

(a) RESIDENCE NO. Alhambra Apts. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Moses

6 DATE OF BIRTH (month, day, and year) Aug. 1 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Horse Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Moses

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob Moses (Address) Alhambra Apts.

15 APR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/1923.

17 I HEREBY CERTIFY, That I attended deceased from , 1919 , to April 11 , 1923 ,

that I last saw h alive on April 11 , 1923 ,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) McClain Sondheim, M. D.

, 19 (Address) 1222 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Friendship Cem DATE OF BURIAL 4/13/1923

20 UNDERTAKER David Sondheim ADDRESS 17 20 W mt. Royal Ave

mation should be carefully supplied. Avoid CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation may be of certificates. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D74739

HEALTH DEPARTMENT—CITY OF BALTIMORE D74739

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. ... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Samaritan~~ Rosenstock.

(a) RESIDENCE NO. Hebrew Hospital and Asylum ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Cash yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ✓

9 BIRTHPLACE (city or town) ... (State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) ... (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country)

14 Informant Hosp Records.

(Address)

15 FILED APR 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1923, to April 10, 1923, that I last saw him alive on April 10, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal)

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Irvin Gellman, M. D.

April 1, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beth Shalom Cem	4/12/1923
20 UNDERTAKER	ADDRESS
Durd Sondheim	1119 W. Pratt St. Royal Cove.

N. B. ... mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D74740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D74740

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2601-N-Charles St., V7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel May Davis

(a) Residence No. 2601-N-Charles St., 12 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 80 yrs. 1 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William H. Davis

6-DATE OF BIRTH (month, day and year) March 6 1843

7-AGE, 80 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country). Elkton Maryland

PARENTS.

10-NAME OF FATHER. James Crouch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Elkton Md

12-MAIDEN NAME OF MOTHER. Caroline May

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Elkton Maryland

14-Informant Mrs Esther D. Pease Niece

(Address) Washington D.C.

15-Filed..... 192.....

ROBERT R. KRAUTER, Registrar.

APR 12 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 11 23

17-I HEREBY CERTIFY, That I attended deceased from April 2 1923 to April 11 1923

that I last saw h.. alive on April 11 1923

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia y Diam

Cardiac Contraction

3 days

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. 1 mos. 10 ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) John A. Evans M. D

19 (Address) 101 N Eden

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Hill Cemetery

DATE OF BURIAL. April 13, 1923

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Should be carefully filled. Exact statement of cause of death may be properly classified. In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74741 ✓

D74741

135

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) Md. Genl Hospital ST., 11 WARD)

2-FULL NAME Louis Edward Bartell

(a) RESIDENCE NO. Earl Court Apts. ST., 11 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? 68 yrs. 6 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of Katharine Clark Bartell

6 DATE OF BIRTH (month, day, and year) Sept. 23-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	68	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Grain Merchant

(c) Name of employer: (none)

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Christopher Bartell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Eudenka Boxell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): Mr. Geo. E. Bartell (Son) 1612 20 North Ave City

15 Filed APR 12 1923 19 ROBERT N. KRAUTH, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/23

17 I HEREBY CERTIFY, That I attended deceased from 4/2/23, 19 .. to 4/10/23, 19 .., that I last saw h alive on 4/10/23, 19 .., and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Ileus paralyticus

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchitis Hypostatic Pneumonia (duration) 18 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of 4/16/23

Was there an autopsy? No

What test confirmed diagnosis? Clynical Symptoms

(Signed) J. A. Simpkins M. D.

19 (Address) Md Gen Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: April 17, 23

20 UNDERTAKER: STEWART & MOWEN COMPANY, WILLIAM F. WOODEN, Successor — ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. Exact statement of occupa
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

Form 1871 MAY 1940 Rev.

D74742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D74742

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 Jefferson ST., 7 WARD)

2-FULL NAME John H. Bozman

(a) RESIDENCE NO. 2114 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bozman

6 DATE OF BIRTH (month, day, and year) May 2, 1865

7 AGE Years 57 Months 11 Days 9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship-Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John W. Bozman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Bozman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Bozman

(Address) 2114 Jefferson

15 Filed APR 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1923

17 I HEREBY CERTIFY, That I attended deceased from April 9 1923, to April 11 1923, that I last saw him alive on April 11 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

La Grippe

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) mos. 5 ds.

18 Where was disease contracted (duration) yrs. mos. ds. if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Finding

(Signed) [illegible] M. D.

19 (Address) 700 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL April 13 1923

20 UNDERTAKER Forker & Forker ADDRESS 1734 Eutaw

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74743

HEALTH DEPARTMENT—CITY OF BALTIMORE

128 D74743

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Bank & Milton ave ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Lamana
Superintendent

(a) RESIDENCE NO. Bank & Milton ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles J. Lamana

6 DATE OF BIRTH (month, day, and year) Nov. 6 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): 0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS
10 NAME OF FATHER: Andrew Krauss
11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria
12 MAIDEN NAME OF MOTHER: Lizzie Mazofe
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Chas. J. Lamana
(Address): Bank & Milton

15 FILED APR 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1923

17 I HEREBY CERTIFY, That I attended deceased from April 7 1923 to April 11 1923.
that I last saw her alive on April 11 1923.
and that death occurred, on the date stated above, at 3.30 a. m.
The CAUSE OF DEATH* was as follows:
Acute Dilatation
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Anemia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Fred C Jewett, M. D.
, 19 (Address) 2516 Penn. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill. DATE OF BURIAL: April 14 1923

20 UNDERTAKER: Pinkler & Pinkler ADDRESS 1739 Eager

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition known.

Spec.—1-10-21—MAT—1500 Blks.

D74744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

T/H-001 D74744

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 727 Glenwood Ave ST., Gorsuch (WARD) 27

2-FULL NAME Sarah Emma Dowling

(a) RESIDENCE NO. 727 Glenwood Ave ST., Gorsuch WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry E. Dowling

6 DATE OF BIRTH (month, day, and year) July 18th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Julius Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry E. Dowling (Address) 727 Glenwood Ave Gorsuch

15 APR 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11th, 1923, to Apr 11, 1923, that I last saw h[illegible] alive on Apr 11, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) High arterial pressure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Residence

Did an operation precede death? no Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. K. Duncan M. D.

Apr 12 1923 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL [illegible]

20 UNDERTAKER [illegible] J. Horlocks — ADDRESS [illegible] W. Baltimore St

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74745

CERTIFICATE OF DEATH.

X 66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Whitmore

(a) RESIDENCE NO. Belair Road Belair Md. ST., WARD Belair Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 43 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carriage Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0 16

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER David G. Whitmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs. J. H. Knight Overlea, Md.

15 Robert P. Harrison, M.D. Registrar

Burial Permit Clerk.

APR 12 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1923, to April 11, 1923, that I last saw him alive on April 11, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Serous meningitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? C.S. & S.

(Signed) John J. Kraper, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Apr. 12 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E. Eager St

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74746 D74746

CERTIFICATE OF DEATH. 146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 N. Central Ave St. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Greenwald

(a) RESIDENCE NO. 1221 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 2nd 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 169

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J. Greenwald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sophia T. Spahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Sophia T. Greenwald

(Address) 1221 N. Central Ave

15 Robert F. Garrison, Registrar

, 19

R 121923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5th 23, to April 13th 23, that I last saw h alive on April 11th, 19, and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

The Terminal State

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. O. Palmer, M. D.

, 19 (Address) 1801 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr. 14 1923
20 UNDERTAKER	ADDRESS
Henry Horch Son	1801 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 110 21 MAY 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74747

CERTIFICATE OF DEATH.

100-001

D74747

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Brewer

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~Wife~~ of Laura L. Brewer

6 DATE OF BIRTH (month, day, and year) Sept 6 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 Filed ....., 19 ..... Robert F. Harrison. Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1923

17 I HEREBY CERTIFY, That I attended deceased from January 22, 1923, to April 11, 1923, that I last saw him alive on April 11, 1923, and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Senile deterioration

~~and of importance~~ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard L. Badgley M. D.

4-11 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Apl 13 1923
20 UNDERTAKER Wm J Tickner & Son	ADDRESS North Ave

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D74748 HEALTH DEPARTMENT—CITY OF BALTIMORE D74748

CERTIFICATE OF DEATH. 74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3027 Clifton Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Claudius S. Foster

(Residence in Baltimore: No. 3027 Clifton Ave St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 7 (Day) 1861 (Year)

7-AGE, 63 yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Broker
(b) General nature of industry, business, or establishment in which employed (or employer) & Life Ins.

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Shepherd Foster

11-BIRTHPLACE OF FATHER, (State or Country), Va. Scotland

12-MAIDEN NAME OF MOTHER, Virginia Foster

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry S. Foster

(Address) 3403 Piedmont Ave

15- Robert P. Harrison, Registrar.

APR 12 1923

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. O. Tennessy M. D.
(Coroner.)

April 12 1923 (Address) 2502 Edmonson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Apl 13 1923

20-UNDERTAKER, W. J. Mackenson ADDRESS Hooker Pa

Every item of information must be properly classified. Exact statement of occupation must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec. 1-10-21 MAT 1500 Rbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74749

CERTIFICATE OF DEATH.

65-001 D74749

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene St. 11 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Smith

(a) RESIDENCE NO. #4 Orchard Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND (or) WIFE Mary Gertrude Smith

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS
10 NAME OF FATHER Thomas Smith
11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)
12 MAIDEN NAME OF MOTHER Anna Manning
13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Gertrude Smith
(Address) 4 Orchard St

12 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/8, 1923, to 4/10, 1923.
that I last saw him alive on 4/10, 1923.
and that death occurred, on the date stated above, at 5.30 P. m.
The CAUSE OF DEATH* was as follows:
Acute Lymphatic Leukemia

(duration) ... yrs. ... mos 20 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? Outside
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy & clinical findings
(Signed) Jno Jordan M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral bem — DATE OF BURIAL 4/14/1923

20 UNDERTAKER J. G. Moran — ADDRESS 3000 E Baltimore

TRO 6762

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74750

D74750

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 N. Carrollton Ave. WARD 18)

2-FULL NAME Viron Joseph McCurley.

(a) RESIDENCE. No. 304 N. Carrollton Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 5 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James B. McCurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mina E. Emrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) James B. McCurley 304 N. Carrollton Ave.

15 R 1 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....,

that I last saw h.... alive on ....., 19....,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jno. O'Bound, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	4/13 1923
20 UNDERTAKER	ADDRESS
J. G. Moran	E Balto.

D74751 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74751

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 912 N. Wellington ST. 7 WARD)
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Hillenbrand
(Residence in Baltimore: No. 912 N. Wellington ave St.; yrs., life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) 1 (Day) 1865 (Year)

7-AGE, 57 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tackler
(b) General nature of industry, business, or establishment in which employed (or employer): Stove Mfg. Co

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Antony Hillenbrand

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Anna Moller

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Christian Hillenbrand
(Address) 912 N. Wellington ave

15- Robert P. Harrison, Burial Permit Clerk. Registrar.
..... 191.....

NOV 12 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 10 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gas Asphyxiation
(Suicide)
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) H. H. Haller M. D.
(Coroner)
4/10/23 191... (Address) 508 E. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, April 13, 1923

20-UNDERTAKER Geo M. Fink & Son — ADDRESS 511 W. North Ave

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–1-10-21–M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D74752 — CERTIFICATE OF DEATH. — 135 — D74752

1-PLACE OF DEATH University Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. 20 ST. ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin J. Hooper

(a) RESIDENCE NO. 2503 Emerson St, ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Louisa Hooper

6 DATE OF BIRTH (month, day, and year) 12/6/3

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Store Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Thomas Hooper
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Elizabeth Cadd
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant University Hosp. records (Address)

15 Robert P. Harrison, ..., 19 ... Registrar
Burial Permit Clerk.

R 12 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/16, 1923, to 4/10, 1923, that I last saw him alive on 4/10, 1923, and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:
Prostatic calculi - 6 wks.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis - 2 wks.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 3/22/23
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Anthony V. Buchanan, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick Cemetery	April 13 1923
20 UNDERTAKER	ADDRESS
Jno E. Miller	2334 Hoffman

mation should be carefully supplied. AGE should be stated EXACTLY. Illegible or incomplete CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74753

CERTIFICATE OF DEATH.

90

D74753

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2646 Harlem Ave ST., 16 WARD)

2-FULL NAME Annie M Butterbaugh

(a) RESIDENCE NO. 2646 Harlem Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Butterbaugh

6 DATE OF BIRTH (month, day, and year) ? 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Walter C Bacon

(Address) 100 E 20

15 Robert P. Harrison, Burial Permit Clerk. Registrar

R 121923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/23 19

17

I HEREBY CERTIFY, That I attended deceased from Jan 25, 1923, to Month April 11 1923,

that I last saw her alive on April 11, 1923,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Endo Carditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Time of Disease

(Signed) Walter C Bacon, M. D.

4/12/23 (Address) 100 E 20 Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Hill Cem	April 13 1923
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	2178 Pen

IMPORTANT—CERTIFICATE should be stated EXACTLY. TITLES OR DEGREES should not be given. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74754

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 16 Kelley Ave ST., 27 WARD)

2-FULL NAME Oliver Clark

(a) RESIDENCE NO. 16 Kelley Ave. Mt Washington, Md WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Clark

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Axle Plant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Elizabeth Clark

(Address) 16 Kelley Ave

15 Filed 1 2 1923, 19 Robert J. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 4th, 1923, to Apr 10th, 1923, that I last saw him alive on Apr 10th, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Harry F Brown, M. D.

4/12 1923 (Address) 501 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetary	April 13 1923
20 UNDERTAKER	ADDRESS
Florence E Wright	1364 Mary

AGE should be stated EXACTLY. PHYSICIANS should be careful in filling this certificate. Exact statement of OCCUPATION should be carefully supplied. AGE, that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74755 ✓ D74755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 16129

City of BALTIMORE: (No. 3028 Pulaski St., St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward L Reed

(a) Residence No. 3028 Pulaski St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Agnes Watts

6-DATE OF BIRTH (month, day and year) Feb 21 77

7-AGE. 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). N. H

PARENTS.

10-NAME OF FATHER. John Reed

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Mass

12-MAIDEN NAME OF MOTHER. Eliza Hutchinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Mass

14-INFORMANT. Mrs. Edward Reed

(Address) 3028 Pulaski St.

15-Filed. Robert P. Harrison, Registrar.

R 12 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 10 1923

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1922 to April 10 1923

that I last saw him alive on April 10 1923

and that death occurred, on the date stated above, at 1-30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) yrs. 9 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Walter W Shoch M. D.

4-11-1923 (Address) 806 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Ward Lawn — DATE OF BURIAL. April 13, 1923

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Fort Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74756 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74756

CERTIFICATE OF DEATH. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 N Chester ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Braun

(a) RESIDENCE NO. 1724 N Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad Braun

6 DATE OF BIRTH (month, day, and year): April 6 1857

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. C. Braun Relative

(Address) 1724 N Chester St

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Mark.

R 12 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to April 17, 1923, that I last saw h er alive on April 11, 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): General Metastasis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John F. Fitch, M. D.

4/19 1923 (Address) 93 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: April 14 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74757

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 St Paul St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Higgins

(Residence in Baltimore: No. 710 St Paul St. 6 St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (~~Write the word.~~)

6-DATE OF BIRTH: June (Month) 11 (Day) 1854 (Year)

7-AGE: 66 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: atty
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: James Higgins

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country): Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanch Higgins

(Address) 710 St Paul St

15-

Filed APR 12 1923 Robert P. Harrison, Registrar.

~~Burial Permit Clerk~~

CORONER'S CERTIFICATE OF DEATH. 3-am

16-DATE OF DEATH, Apr. (Month) 12 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) Geo Clinton Dr Coles M. D.

Apr 12 1923 (Coroner.) (Address) 4 E Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cambridge Md — DATE OF BURIAL, 4/13 1923

20-UNDERTAKER, J W Cook — ADDRESS 502 E North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74758 — 74-001 — D74758

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 814 Bruce St. St. 16 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Braddy

(Residence in Baltimore: No. 814 Bruce St. St.; yrs. 6 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, About ....., 1866
(Month) (Day) (Year)

7-AGE, 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Odd

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. W. Police Dept.

(Address) Penna. Ave.

15- APR 13 1923 Filed ....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH April 1, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) No History

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 10, 1923 (Address) 200 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND. DATE OF BURIAL, ..., 19....

20-UNDERTAKER Commissioner Health. ADDRESS APR 12 1923

THE MORGUE.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74759

CERTIFICATE OF DEATH.

182 D74759

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Ann St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Unknown

(Residence in Baltimore: No. Unknown St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Unknown

6-DATE OF BIRTH. Unknown

(Month) (Day) (Year)

About 50 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)..... 08

9-BIRTHPLACE, (State or Country) Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

Address Eastern Dist

15-

Filed APR 13 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8 1923

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Supposed Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. B. Norton M. D. Coroner.

April 10 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Co.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY. DATE OF BURIAL APR 12 1923 19..

20-UNDERTAKER. Commissioner Health. ADDRESS

Par. Wm. E. WOODALL.

N. B.—Every item of information should be carefully supplied. Age must be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74760

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-01

D74760

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lloyd C. Askew

(Residence in Baltimore: No. 718 Linden Avee St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write this word.)
male	Black	Single

6-DATE OF BIRTH, Dec. 10/1921, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 4 mos. 0 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George T. Askew

11-BIRTHPLACE OF FATHER, (State or Conntry), N.C.

12-MAIDEN NAME OF MOTHER, Mollie A. Smith

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. T. Askew

(Address) 718 Linden Ave

15-APR 13 1923 Filed 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10/23 (Month) (Day) (Year) 192

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Convulsions)

(Autopsy at hospital)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Owen M. D. (Coroner.)

4/12/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	April 13th 1923
20-UNDERTAKER.	ADDRESS
Jno. M. Johnson	1234 Eutaw St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74761

CERTIFICATE OF DEATH.

X 31 D74761

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. M. J. H. ST., 14 WARD)

2-FULL NAME Dallis Phipps

(a) RESIDENCE NO. 1614 Argyle ST., ... WARD N. 6.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North
(State or country) Carolina

PARENTS

10 NAME OF FATHER Frank Phipps

11 BIRTHPLACE OF FATHER (city or town) North
(State or country) Carolina

12 MAIDEN NAME OF MOTHER Fannie Smith

13 BIRTHPLACE OF MOTHER (city or town) North
(State or country) Carolina

14 Informant Harvey Phipps
(Address) 1614 Argyle Ave

15 Filed APR 13 1923, ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1923

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1923, to April 8, 1923, that I last saw h[illegible] alive on April 8, 1923, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X-Ray

(Signed) Francis L. Dabyshaw M. D.

(Address) 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	4/13 19 23
20 UNDERTAKER James H. Lewis	ADDRESS 1203 Eastern

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. Physicians should be particular in filling out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Ida Kilmenck)

D74762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74762

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 115 aisquith Street Hebrew Aged Home ST. 5 WARD).

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Kilmenck (Kilimanick

(a) RESIDENCE NO. 115 aisquith Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1830

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Old age

(b) General nature of industry, business, or establishment in which employed (or employer) none (Wid)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lauis (Address) 1439 Eutaw St

15 APR 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1923, to April 12th, 1923.

that I last saw her alive on - , 1923

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L Winner M. D.

4-12-1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	4/13 1923
20 UNDERTAKER	ADDRESS
Jack Lauis	1439 Eutaw St

N. B.—WRITE PLAINLY, with pen and ink. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74763

CERTIFICATE OF DEATH.

129 ✓ D74763

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Edmondson Ave. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Francis Metz

(a) RESIDENCE NO. 1703 Edmondson Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. Ellen Metz

6 DATE OF BIRTH (month, day, and year) Nov. 25th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Letter-Carrier

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Andrew Metz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Isabella J. Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Frances Magill

(Address) 1703 Edmondson Ave.

15 Filed APR 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11th 19 23

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to Apr 11 1923

that I last saw him alive on Apr 11 1923

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen'l debility & Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Bernard S. Lucas M. D.

4/12 23 (Address) 1707 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 13th 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St.

N.B. [illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74764

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 Linden Ave ST., 11 WARD)

2-FULL NAME Eugene Levering Jr

(a) RESIDENCE NO. 1217 Linden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Adelaide L. Gary Levering

6 DATE OF BIRTH (month, day, and year) June 13th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... President

(b) General nature of Industry, business, or establishment in which employed (or employer) Levering Coffee Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Eugene Levering Sr

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Cunsted

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant E. C. Regan
(Address) 1317 Bolton St

15 APR 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1923, to April 12, 1923, that I last saw him alive on April 12, 1923, and that death occurred, on the date stated above, at 9.13 a.m.

The CAUSE OF DEATH* was as follows:

~~Staphylococcus~~ Streptococcus
endocarditis - Septicaemia.
Streptococcus haemolyticus about
(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Gastric infarct. Thrombus
(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Frank R. Krauter, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL April 14 1923

20 UNDERTAKER Wm. Boteler's Sons

ADDRESS Cathedral & Madison Sts

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74765 HEALTH DEPARTMENT—CITY OF BALTIMORE

181-00 D74765

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2227 Oak St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Brooks

(Residence in Baltimore: No. 2634 Hanover St.; yrs. 22 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Unknown (Month) (Day) 1..... (Year)

7-AGE. 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seamstress
(b) General nature of Industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Ind.

PARENTS.

10-NAME OF FATHER. Wm. D. Brooks.

11-BIRTHPLACE OF FATHER, (State or Country). Ind.

12-MAIDEN NAME OF MOTHER. Mary Bachenheimer

13-BIRTHPLACE OF MOTHER, (State or Country). Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Burton

(Address) 2636 Hanover St.

15- Filed APR 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: -

Gas Poisoning

Accident (Verdict)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. F. Morrissey M. D. (Coroner.)

April 11, 1923 (Address) 9632 Pulaski

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Park DATE OF BURIAL, Apl 13 1923

20-UNDERTAKER, Chenoweth & Son ADDRESS Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74766

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Hampden ST., 12 WARD)

2-FULL NAME Lillian Virginia Baker

(a) RESIDENCE NO. 2603 Hampden ST., 12 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, ~~Widowed~~ or Divorced, (write the word): divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓ ✓ ✓

6 DATE OF BIRTH (month, day, and year): Feb 22 1892

7 AGE: Years 31 | Months 1 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Isreal King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary S Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Jno King (Address) 2603 Hampden Ave

15 Filed APR 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1923, to Apr 11, 1923, that I last saw her alive on Apr 11, 1923, and that death occurred, on the date stated above, at 9, P m.

The CAUSE OF DEATH* was as follows:

Nephritis with supression

(duration) not known ds.

CONTRIBUTORY (Secondary) Cardiac manifestiney

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Roscoe Ethos, M. D.

Apl 13, 1923 (Address) 2438 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Md — DATE OF BURIAL: Apl 14, 1923

20 UNDERTAKER: Ebenezer Sons Chestnut Ave — ADDRESS

N. B.—WRITE PLAINLY with pen and ink. Use no abbreviations. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D74767

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Thames ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anila Gnatowska

(a) RESIDENCE NO. 1628 Thames ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Antoni Gnatowski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Antoni Gnatowski (Address) 1628 Thames

15 Received APR 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1923

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1923, to April 11, 1923, that I last saw h[illegible] alive on April 11, 1923, and that death occurred, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Edema of Lungs.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo D Dieijacks, M. D.

4/14 1923 (Address) 2818 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Apl 14 1923

20 UNDERTAKER William Fiegenski ADDRESS Eastern Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis
Reported as Pulmonary
Tuberculosis.

Spec—12-23-21—H.H.H.S.—400 Blks.

D74768

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74768

CERTIFICATE OF DEATH.

16 11-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No.) 2907 Harlem Ave St. (Ward) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Vincenza Guglielizza

(a) Residence No. 2907 Harlem Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Guglielizza

6-DATE OF BIRTH (month, day and year) Dec 25 1846

7-AGE. 76 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Tobacco Dealer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Salvadore Guglielizza

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Maria Guglielizza

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14- (Informant) Joseph Guglielizza

(Address) 2907 Harlem Ave

15- Filed APR 13 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 12 1923

17- I HEREBY CERTIFY, That I attended deceased from April 10 1923 to April 12 1923

that I last saw him alive on April 12 1923

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 12 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hank G. Gillis M. D.

, 19 (Address) 2838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Calvary DATE OF BURIAL, April 14, 1923

20-UNDERTAKER. William Carlson ADDRESS Edmondson

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-2414—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74769

CERTIFICATE OF DEATH.

74 1601

REGISTERED NO. C D74769

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Shields ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Moore

(Residence in Baltimore: No. 1123 Shields St.; 1 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1880 (Year)

7-AGE, 43 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundress
(b) General nature of industry, business, or establishment in which employed (or employer). C. L. Howe

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Jackson Coles

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Lucy Johnson

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Rogers

(Address) 1623 Shields St.

15- APR 751923

ROBERT R. KRAUTER,

Filed ....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 22 1923, to April 10 1923, that I saw h[illegible] alive on March 9 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. 21 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) E. Edwin Langley M. D.

April 11, 1923 (Address) 1628 Bank Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL, April 12 1923

20-UNDERTAKER Edward L. Kemsley ADDRESS 928 Bedford

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74770 X 38 D74770

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 McElderry ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W Adams

(Residence in Baltimore: No. 1920 McElderry St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED.~~ (Write the word.)
male	colored	married

6-DATE OF BIRTH, December (Month) ..... (Day), 1870 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, George Adams

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Lillie Jones

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Miss Fannie Adams

(Address)..... 1926 McElderry St.

15- Filed APR 13 1923. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3/24 191..., to 4/12 1923, that I saw h... alive on 4/6/23 191..., and that death occurred, on the date stated above, at 6.35 m.

The CAUSE OF DEATH* was as follows:

Locomotor ataxia

Myocarditis Chronic

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J McGaneth M. D.

4/12, 1923 (Address) 633-S-Ha

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Virginia

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Culpepper, Va. DATE OF BURIAL, April 14, 1923.

20-UNDERTAKER Robert C. Williams - 1515 ADDRESS McElderry St.

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS, and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74771 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D74771

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pasquale [redacted] Schiavone

(a) RESIDENCE NO. 501 S. Linwood Ave, ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdalene Schiavone

6 DATE OF BIRTH (month, day, and year) April 24 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scissors grinder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Cheronne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Justine Mimots

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Univ. Hospital Records (Address)

15 APR 13 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/4, 1923, to 4/12, 1923, that I last saw him alive on 4/12, 1923, and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Benign hypertrophy of prostate

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/9/23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon Freedom, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 4/12 1923

20 UNDERTAKER Chas Browne & Son — ADDRESS 118 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

pec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74772

CERTIFICATE OF DEATH.

D74772

Registered No. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 728 S Luzerne ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Stachowski

(a) Residence No. 728 S Luzerne ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rapuwacena Stachowski

6-DATE OF BIRTH (month, day and year) Dec 6 1864

7-AGE. 58 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Labor

(b) General nature of industry, business, or establishment in which employed (or employer). 020

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Rapuwacena Stachowski

(Address) 728 S Luzerne ave

15- Filed APR 13 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 11 1923

17- I HEREBY CERTIFY, That I attended deceased from December 26, 1922 to April 11 1923, that I last saw him alive on April 8 1923, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edal H Athey M. D.

April 12 1923 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary

DATE OF BURIAL, April 14, 1923

20-UNDERTAKER. John Maleber

ADDRESS 1803 Bank St

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

~~162714~~ D74773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74773

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST., 3 WARD)

2-FULL NAME Mary Tarnowski.

(a) RESIDENCE NO. 328 S. Bond St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ?? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (HUSBAND of) or) WIFE of: James Tarnowski Husband

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 29 | Months ? | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Joseph Nencycki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Eva Tobryowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Geo. Geaorcky.

15 APR 13 1923 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1923, to April 11, 1923, that I last saw her alive on April 11, 1923, and that death occurred, on the date stated above, at 9 15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis: Hypertension

Uremia - Anuria

..... (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?.....

(Signed) Chas. W. Cunningham M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: April 14 1923

20 UNDERTAKER: John M. Weber — ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH CAREFUL ATTENTION TO SPELLING. All information should be stated EXACTLY. PHYSICIANS should state AGE carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74774

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 S. Ellwood Ave. ST., WARD)

2-FULL NAME Nicholas Pebour

(a) RESIDENCE NO. 707 S. Ellwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Johanna Pebour.

6 DATE OF BIRTH (month, day, and year) July 29 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Lawrence Pebour.

11 BIRTHPLACE OF FATHER (city or town) (State or country) France.

12 MAIDEN NAME OF MOTHER Catherine Rasmussen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France.

14 Informant Johanna Pebour (Address) 707 S. Ellwood Ave.

15 Apr 13 1923, 19 Robert F. Duffiel. Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to April 10, 1923, that I last saw h in alive on April 10, 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. R. Burke, M. D.

, 19 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL April 14 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St

NO B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. DATE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74775

D74775

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 S. Clinton ST., 16 WARD)

2-FULL NAME Joseph Morris

(a) RESIDENCE NO. 938 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Morris.

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER John Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Sarah Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mr Morris (Son)

(Address) 936 S. Clinton St

15 Filed ....., 19..... Robert P. Harrison, Registrar

Jun 12 1923

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 Apr 1923

17 I HEREBY CERTIFY, That I attended deceased from 15 Oct, 1922, to 12 Apr, 1923, that I last saw him alive on 12 April, 1923 and that death occurred, on the date stated above, at 3 45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

My knowledge (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & course

(Signed) D.T. Mohr M. D.

, 19 (Address) 3015 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	April 16 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS MATTER MUST BE TYPEWRITTEN. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates. OCCUPA-

Dr. Heffron

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74776

D74776

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1165 Carroll. ST., 21 WARD)

2-FULL NAME Gertrude E Buettner.

(a) RESIDENCE NO. 1165 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
~~Female~~	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 10-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	2.	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adam. Buettner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Carolina Krzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Adam. Buettner (Address) 1165 Carroll St

15 Filed . 19 Robert P. Garrison, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1 . 1923. to April 13 . 1923.

that I last saw h alive on April 12 . 1923.

and that death occurred, on the date stated above, at 7 35 A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) same (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. Kieffer M. D.

, 19 23 (Address) 2320 Bond, Bal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Park Cem

DATE OF BURIAL 4-16 1923

20 UNDERTAKER James Degnan & Son

ADDRESS 1000 S Paca St

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D74777 HEALTH DEPARTMENT—CITY OF BALTIMORE D74777

CERTIFICATE OF DEATH. 474-001 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 623 Penn alley St., Ward) Pin alley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John White

(Residence in Baltimore: No. 623 Penn alley St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	Mard

6-DATE OF BIRTH. Dont Know (Month) (Day) 1 (Year)

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). " "

12-MAIDEN NAME OF MOTHER. " "

13-BIRTHPLACE OF MOTHER, (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm White

(Address) 623 Penn alley

15- Filed ..... 192 Robert P. HARRISON, Registrar.

APR 13 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 12 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) H K Grason M. D. (Coroner.)

4/13 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. ..... 19..

20-UNDERTAKER. ADDRESS.

Commissioner Health.

APR 13 1923

Per, Wm. E. WOODALL.

UNIVERSITY OF MARYLAND,

P.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74778

D74778

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women Home ST., 19 WARD)

2-FULL NAME Lina Robertson

(a) RESIDENCE NO. 1400 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 94 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Wh	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 4-1829

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
94	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Aquilla Galloway

11 BIRTHPLACE OF FATHER (city or town) Harford Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Snyder

13 BIRTHPLACE OF MOTHER (city or town) Kalorama
(State or country) Maryland

14 Informant Ella Z Jones
(Address) 1400 W Lexington St Balto

15 Filed Apr 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to April 13, 1923, that I last saw h. alive on April 12, 1923, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senile Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Hoorwood, M. D.

Apr 13 1923 (Address) 909 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 14 1923
20 UNDERTAKER George J Smith	ADDRESS 1772 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in giving information should be stated EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should be careful in giving information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 13 1923

Spec.—1-10-21—M&T—1500 Bks.

D74779

HEALTH DEPARTMENT—CITY OF BALTIMORE D74779

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Men's Home ST., 19 WARD)

2-FULL NAME Flora K. McCoy

(a) RESIDENCE NO. 1400 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 27-1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Pa
(State or country)

PARENTS

10 NAME OF FATHER Myer Smith Bailey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Mary M. Kline

13 BIRTHPLACE OF MOTHER (city or town) Lancaster
(State or country) Pennsylvania

14 Informant H. W. Dickman
(Address) Home

15 Robert P. Harrison, Registrar

APR 13 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl 6 1923, to Apl 13, 1923, that I last saw h[illegible] alive on Apl 12, 1923, and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

April 13, 1923 (Address) 8 Jewett Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 14 1923
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D74780 HEALTH DEPARTMENT—CITY OF BALTIMORE D74780

159-002

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 239 arlington ave W. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Palmer

(Residence in Baltimore: No. 239 arlington ave W. St.; yrs. ..... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. April (Month) 10 (Day) 1923 (Year)

7-AGE.	If LESS than 1 day,
..... yrs. ..... mos. 2 ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, Herman Palmer

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER, Nellie Wallace

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Wallace

(Address) 239 Arlington ave

15. Apr 13 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 12 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Foramen Ovale

Asphyxia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H. Hunter M. D.
(Coroner.)

April 13 1923. (Address) Fort Chase Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Cem DATE OF BURIAL, April 14, 1923

20-UNDERTAKER, Brown & Tedandale ADDRESS 114 a. Eastst

Spec.—1-10-21—MAT—1000 Blks.

D74781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74781

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 East Cross ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond H Valentine

(a) RESIDENCE NO. 202 East Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fife yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma M. Valentine

6 DATE OF BIRTH (month, day, and year): Aug 10-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Edwin Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Adeline Picking

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Le. V. Valentine

R 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to April 11, 1923, that I last saw h alive on April 10, 1923, and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont k

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph D. Heyman M. D.

(Address) 1607 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: April 14 1923

20 UNDERTAKER: Chenoweth & Son — ADDRESS: Chestnut Ave

B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

D74782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74782

CERTIFICATE OF DEATH.

113

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 8 Fear Ave. ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Geo. McCarthy

(Residence in Baltimore: No. 8 Fear Ave. St.: yrs. 3 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH. Dec. 23, 1919
(Month) (Day) (Year)

7-AGE. yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Albert R. McCarthy

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Marie Diseney

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Marie McCarthy
(Address) 8 Fear Ave.

15- Robert P. Harrison,
Filed ....., 191.... Registrar.

P R 13 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. gastro-enteritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

Signed) J. T. Hennessy M. D.
(Coroner.)
April 12, 1923 (Address) 201 Redwood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral
DATE OF BURIAL. 4 14 1923

20-UNDERTAKER H. C. Blanchard & Son
ADDRESS 511 N. Eutaw St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D74783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74783

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2232 Oak St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Williams

(a) RESIDENCE. No. 2232 Oak ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Hallock B Williams

6 DATE OF BIRTH (month, day, and year): Sept 12-1843

7 AGE: Years 79. Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Francis King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Baily

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hallock Williams

(Address): 607 N Fulton

15 Filed APR 13 1923 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1923

I HEREBY CERTIFY, That I attended deceased from 3/30, 1923, to 4/12, 1923, that I last saw her alive on 4/12, 1923 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart Disease

Several Years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank W Wells M. D.

4/13 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: April 14 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North

Burial Permit Clerk.

I.—WRITE PLAINLY, with pen and ink. PHYSICIAN'S and undertaker's certificates should be stated EXACTLY. PHYSICIAN'S OCCUPATION and AGE should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74784 D74784

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 150 N. Ster. ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Baltrum.

(a) RESIDENCE NO. 150 N. Peter ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) Dec. 15. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto- Md

PARENTS

10 NAME OF FATHER Maurice Baltrum.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rose Rosenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Maurice Baltrum.

(Address) 150 N. Peter St.

15 Filed ....., 19.... Robert F. Carrison Burial Permit Clerk, Registrar

PR 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11. 1923. to Apr. 13. 1923

that I last saw h[illegible] alive on Apr. 12. 1923

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) W. L. Steinmeyer, M. D.

4/14 1923 (Address) 628 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery, Balto

DATE OF BURIAL 4/14 1923

20 UNDERTAKER W. H. Cook

ADDRESS 502 E. Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should supply information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74785

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH 110 S. Fulton Ave.,

CITY OF BALTIMORE: (No. 110 S. Fulton Ave., ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel H. Althoff

(a) RESIDENCE. No 110 S. Fulton Ave., ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Schilling Althoff

6 DATE OF BIRTH (month, day, and year) May. 10. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Claim Adjuster.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railway.

9 BIRTHPLACE (city or town) Hanover,
(State or country) Pa.

PARENTS

10 NAME OF FATHER Louis Althoff

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa/

12 MAIDEN NAME OF MOTHER Florence Morrow

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Annie Schilling Althoff
(Address) 110 S. Fulton Ave.

APR 14 1923

15 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 12, 1923, that I last saw him alive on April 12, 1923, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G. E. Burton, M. D.

4/13. 1923 (Address) 301 East Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	4/16 1923

20 UNDERTAKER Harry H. Witzke. ADDRESS 1531 N Lombard St

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74786

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3823 Dalrymple Ave. ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jane Anderson

(a) RESIDENCE NO. 3823 Dalrymple Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. P. Anderson

6 DATE OF BIRTH (month, day, and year) March 29" 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	-	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. Todd Kesterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Sophie A. Woods

(Address) 3823 Dalrymple Ave.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 14 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12" 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 1917, to April 12th, 1923.

that I last saw h. alive on April 12th, 1923,

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma choroid.

left eye -

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General metastases

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1917

Was there an autopsy? No.

What test confirmed diagnosis? Clinical -

(Signed) Frederick A Besley, M. D.

4/13 1923 (Address) Halethorpe, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet, Md.	Apr. 14, 23
20 UNDERTAKER Joseph B Cook,	ADDRESS 1003 W. Lafayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74787

CERTIFICATE OF DEATH.

57 D74787

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Riggs Ave ST., 16 WARD)

2-FULL NAME Margaretta C. Howard

(a) RESIDENCE NO. 1305 Riggs Ave ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5th yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER William Howard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emeralda Graham

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant William H. Howard
(Address) 1305 Riggs ave

15 Filed 1923 Robert P. Harrison, Registrar

PR 14 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 13 Apl 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to 13 April, 1923.

that I last saw he alive on 12 April, 1923.

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute rheumatism, mitral insufficiency, nephritis etc.

(duration) over 4 mos. ds.

CONTRIBUTORY (Secondary) nephritis, cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

D'd an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical chem

(Signed) Theadford Rose M. D.

(Address) 727 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL April 16 1923

20 UNDERTAKER Chas. E. Wright — ADDRESS 736 McCulloh

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74788

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74788

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Bolton ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Salaber

(a) RESIDENCE NO. 2013 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael

6 DATE OF BIRTH (month, day, and year) 9 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pawnbroker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Meyer J Salaber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marion Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Meyer J. Salaber

(Address) 2013 Bolton St

15 Filed Apr 14 1923 Robert P. Garrison, Jr. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from January, 1922, to April 13, 1923, that I last saw him alive on April 12, 1923, and that death occurred, on the date stated above, at 9.55 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mel

about

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Dis Heart

(duration) Years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank Thayer, M. D.

, 19 (Address) 1500 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cemetery	Apr 15 23
20 UNDERTAKER J Ahrens & Co	ADDRESS 1611 Madison Ave

PR 14 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74789

HEALTH DEPARTMENT—CITY OF BALTIMORE

21 D74789

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Minder.

(a) RESIDENCE NO. 2468. Highland Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of Helena Minder

6 DATE OF BIRTH (month, day, and year) Sept 11-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Pierson & Son.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Minder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helena Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Henry Minder

(Address) 240. S. Highland Ave

15 Filed ....., 19.... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1923

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to April 12, 1923, that I last saw him alive on April 11, 1923, and that death occurred, on the date stated above, at 2:35A m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) - yrs. - mos. 20 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) - yrs. - mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B MacLennan, M. D.

4/12/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 14 1923

20 UNDERTAKER	ADDRESS
Geo. F. Ruth	1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item mation should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 14 1923

Spec.—8-24-14—M. & T.—2000 Bks.

D74790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D74790

REGISTERED No. C.....

1-PLACE OF DEATH Southern Hospital.

CITY OF BALTIMORE: (No. 2520 Guilford Ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah Kirk

(Residence in Baltimore: No. ~~2520 Guilford Ave~~ Belair Md St.; ....yrs. ....mos. 4 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, widower OR DIVORCED. (*Write* the word.)

6-DATE OF BIRTH, ... Aug (Month) ..... (Day) 1831. (Year)

7-AGE, 81 yrs. ....mos. ....da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Miller
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Harford County.

PARENTS.

10-NAME OF FATHER, Caleb Kirk.

11-BIRTHPLACE OF FATHER (State or Country), Del.

12-MAIDEN NAME OF MOTHER Hannah Peach

13-BIRTHPLACE OF MOTHER (State or Country), Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertram L. Kirk

(Address) 602 E. 34th St.

15- Robert P. Harrison,

Filed....., 191.....

Registrar.

APR 14 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Apr. 12, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 8 1923, to Apr. 12 1923, that I saw him alive on Apr. 12 1923, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration) 8 yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Left hemiplegia

(Duration) ....yrs. 7 mos. ....da.

(Signed) Dudley P. Bowe M. D.

Apr. 13, 1923 (Address) 104 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 da. In the State whole life yrs. ....mos. ....da.

Where was disease contracted, if not at place of death? Belair, Md

Former or usual residence Belair, Md

19-PLACE OF BURIAL OR REMOVAL. Belair Md Grant Zion Cemetery

DATE OF BURIAL. Apr. 14, 1923

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS giving CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

D74791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74791

CERTIFICATE OF DEATH.

148

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia M. German.

(a) RESIDENCE NO. 1618 Darley ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J L German

6 DATE OF BIRTH (month, day, and year): May 1901

7 AGE: Years 21 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

37

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Vondekin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Hall.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: S. Hall. (Address) 1618 Darley.

15 Filed APR 14 1923, 19 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923. to April 17, 1923.

that I last saw her alive on April 17, 1923.

and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Pregnancy.

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lionel L. Vonder, M. D.

, 19 (Address) 1114 Harford Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: April 14 1923

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74792

CERTIFICATE OF DEATH.

90 D74792

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5234 Parkheights Ave. WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian Freyer.

(Residence in Baltimore: No. 5234 Parkheights Ave. City yrs., mos. ds.)

WRITE PLAINLY.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS would state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April (Month) 6 (Day), 1859 (Year)

7-AGE, 64 yrs. mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Henry Freyer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Catherine Buchner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie C. Freyer

(Address) 5234 Parkheights Ave

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

APR 14 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1922, to April 11 1923, that I saw h[illegible] alive on April 10 1923, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis mitral regurgitation (Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation (Duration) yrs. mos. 3 ds.

(Signed) C. B. Edmunds M. D.

April 13 1923 (Address) 5016 Park north ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, April 14 1923

20-UNDERTAKER Israel Lyser

ADDRESS 16 South [illegible]

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74793

CERTIFICATE OF DEATH.

D74793

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2428 W. Lanvale ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara K. Spicer

(a) RESIDENCE. No. 2428 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of: Hiram H. Spicer

6 DATE OF BIRTH (month, day, and year): Nov 28. 1858

7 AGE — Years: 64 — Months: 3 — Days: 13 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Kansas

PARENTS

10 NAME OF FATHER: John T. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Somerset Co Md

14 Informant: H. H. Spicer
(Address): 2428 W. Lanvale St

15 Filed APR 14 1923, 19 — Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): APR 13 1923 19

17

I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1923. to Apr. 13, 1923.

that I last saw her alive on Apr. 13, 1923

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Dermatitis Exfoliativa

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis with Uraemic Coma (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs + Symptoms

(Signed) R. C. Metzel, M. D.

(Address) 1903 W. Mounty av.

APR. 14 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION ~~OR REMOVAL~~: Mt Olivet — DATE OF BURIAL: APR 16 1923

20 UNDERTAKER: Geo W Little — ADDRESS 2700 EDMONDSON AVE.

APR 14 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Lottie Stewart)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74794

D74794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 N. Dallas ST.: 6 WARD) REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Stewart

(a) RESIDENCE. No. 430 N. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all her life yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem. | 4 COLOR OR RACE: Col. | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James N. Stewart

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: James Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): James N. Stewart 430 N. Dallas St.

15 Filed APR 14 1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to April 12, 1923, that I last saw her alive on April 11, 1923, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows: Nephritis general anasarca etc.

(duration) years. mos. ds.

CONTRIBUTORY (Secondary): Uremia, etc.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? no Date of,

Was there an autopsy? no

What test confirmed diagnosis? Physical & Chemical

(Signed) Crawford Boyd M. D.

(Address) 1017 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	April 15 1923
20 UNDERTAKER	ADDRESS 1631
Edward Bryson	Orleans St

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES must be made in ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required by law to report at once the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74795

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D74795

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. North Broadway ST., 6 WARD)

2-FULL NAME Mrs. Sabina C. Meyers

(a) RESIDENCE NO. 2422 E. Fayette St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 54 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Charles F Meyers

6 DATE OF BIRTH (month, day, and year) March 28th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	—	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER Frederick Harmon
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Rosalia Hartmann
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles F Meyers (Address) 2422 E Fayette st

15 Filed APR 14 1923 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7 , 1923 , to Apr. 12 , 1923 , that I last saw her alive on Apr. 12 , 1923 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Caecum

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Apr. 7
Was there an autopsy? No Operation
What test confirmed diagnosis?
(Signed) Cayetano Cabrera, M. D.
, 19 (Address) Church Home Balto City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL April 16th 1923

20 UNDERTAKER George B Schilling & Sons — ADDRESS 426 E Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74796 D74796 D74796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 5 WARD)

2-FULL NAME Herman Weingel

(a) RESIDENCE NO. 339 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Sept. 28-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Weingel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Desch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Robert F. Harrison, Registrar

. 19 Burial Permit Clerk.

APR 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1923

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1923, to April 7, 1923, that I last saw him alive on April 7, 1923, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. R. Bagg M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL . 19 APR 12 1923

20 UNDERTAKER Commissioner Health,

ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74797 D74797

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST. V WARD)

2-FULL NAME John Butcher

(a) RESIDENCE No. 117 W. York St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Hospital records

15 Filed APR 14 1923 . 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to April 12, 1923, that I last saw h... alive on April 12, 1923, and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John DeLamar M. D.

. 19 (Address) South Falls Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL APR 13 1923

20 UNDERTAKER Commissioner Health, per. Wm E. WOODALL

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE sho CAUSE OF DEATH in plain terms, so that it ma TION is very important. See Instructions on ba

Spec—12-23-21—E.B.R.S.—400 Bks.

D74798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74798

CERTIFICATE OF DEATH.

91-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1900 Linden Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James William Denny

(a) Residence No. 1900 Linden Ave St., 14 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 84 yrs. 4 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Denny

6-DATE OF BIRTH (month, day and year): Nov 28 1838

7-AGE: 84 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer): Law

(c) Name of employer: Self

9-BIRTHPLACE (city or town) (State or Country): Frederick Co, Virginia

PARENTS.

10-NAME OF FATHER: Robt L. Denny

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Frederick Co Virginia

12-MAIDEN NAME OF MOTHER: Eliza Piper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Frederick Co Virginia

11- (Informant): Mr. Harry L. Denny Son

(Address): 19-W-Lanvale St.

15- APR 14 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 12-1923

17- I HEREBY CERTIFY, That I attended deceased from April 9 1923 to April 11 1923

that I last saw h... alive on April 11 1923

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration) 3 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? not any

(Signed) J. D. Lehmann M. D

4/12 1923 (Address) 1926 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Remains

DATE OF BURIAL: Apr 14 1923

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shot in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74799

HEALTH DEPARTMENT—CITY OF BALTIMORE

47

D74799

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 Overhill Road St., 27 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Lumpkin McCullough

(a) Residence No. 7 Overhill Road St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jos. Allen McCullough

6-DATE OF BIRTH (month, day and year) Feby 19, 1861

7-AGE. 62 yrs. 1 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Robert L. Lumpkin

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Va

12-MAIDEN NAME OF MOTHER, Sue Ferry

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Balto. Md.

14- (Informant) Sue Clark L. Barrett

(Address) 4 Overhill Road

15- Filed APR 14 1923 19.. Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 12/23

17- I HEREBY CERTIFY, That I attended deceased from July 31, 1922, to April 12, 1923, that I last saw h.er alive on April 12, 1923, and that death occurred, on the date stated above, at 7.30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma (mammary)

Metastasis to Bones

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) — yrs. — mos. 9 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1919

Was there an autopsy? No

What test confirmed diagnosis? Microscopic; Radioscopic

(Signed) Louis P. Hamburger, M. D.

April 13, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. Apr. 14, 1923

20-UNDERTAKER. John O. Mitchell ADDRESS 1201 W. Fayette St.

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 216 Hawthorne Road St., 27 Ward)

Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Sisco

(a) Residence No. 216 Hawthorne Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Sisco

6-DATE OF BIRTH (month, day and year) Aug 18 1839

7-AGE, 83 yrs. 7 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Sisco

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Ann Harper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Steuen E. Sisco

(Address) 216 Hawthorne Road

15- Robert P. Harrison,

Filed ....., 19.. Registrar.

APR 14 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 13. 23

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1921, to April 12, 1923, that I last saw h.. alive on April 12, 1923, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C Clarke, M. D.

4/12, 1923 (Address) Latrobe Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge — DATE OF BURIAL, April 14 1923

20-UNDERTAKER, John Oettichell — ADDRESS 120 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74801

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

2-FULL NAME Grant Johnson

(a) RESIDENCE NO. Sparrows Point ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Son of Neal and Martha Gayle

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) Schoolboy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Neal Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Gayle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records. (Address)

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

APR 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 19 23

17

I HEREBY CERTIFY, That I attended deceased from April 12, 19 23. to April 12, 19 23.

that I last saw him alive on April 12, 19 23.

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Acute Perforated Appendicitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Toxemia Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 4/12/23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) C. M. Shipley, M. D.

4-13-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	April 15, 1923
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	Ashland Ave

MARGIN RESERVED FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

WRITE PLAINLY. WHERE ANSWER IS NONE, WRITE "NONE." WHERE UNKNOWN, STATE "UNKNOWN."

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74802 HEALTH DEPARTMENT—CITY OF BALTIMORE 202 D74802

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 So. Curley St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Marie Phyllis Cawley

(Residence in Baltimore: No. 19 So. Curley st St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Apr 30th 1920 (Month) (Day) (Year)

7-AGE. 2 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Rodiek J. Cawley

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Annie M. Taylor

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rodiek J. Cawley

(Address) 19 So. Curley St

15- Robert P. Harrison,

Filed..... 192.....

APR 14 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 12th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Caught neck between 2 boards

(Duration) yrs. mos. ds.

(Signed) Thos B. Norton M. D. (Coroner)

Apr 12th 1923. (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Int. Cozmelbem DATE OF BURIAL. 4/14/1923

20-UNDERTAKER. J. A. Moran ADDRESS 3000 E. Balto St.

Spec.—1-10-21—M&T—1500 Blks.

D74803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74803

CERTIFICATE OF DEATH.

41

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 10 WARD)

2-FULL NAME Thomas May

(a) RESIDENCE No. 661 N. Stirling ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine May

6 DATE OF BIRTH (month, day, and year) Feby 3 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	57	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labatory work.

(b) General nature of industry, business, or establishment in which employed (or employer) Johns Hopkins Hospital

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John May

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Barcae

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant JOHNS HOPKINS HOSPITAL. (Address) .....

15 Robert F. Harrison, Registrar
Burial Permit Clerk

APR 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2 1923, to April 11, 1923, that I last saw h alive on April 11, 1923, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Hemorrhoids (duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of April 4

Was there an autopsy? No Blood culture

What test confirmed diagnosis?

(Signed) E. Holman M. D.

4/11, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem. DATE OF BURIAL 4/14 1923

20 UNDERTAKER L. P. Fasselbaugh 2620 ADDRESS St Paul st

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—

Spec.-12-23-21-E.B.P.S.-400 Blks. George B. Loden

D74804

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74804

CERTIFICATE OF DEATH.

101-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 N. Gilmor Street St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. Loden

(a) Residence No. 12 N. Gilmor Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 4- 1891

7-AGE.	If LESS than 1 day,
31 yrs. 5 mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Daniel J. Loden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Maryland

12-MAIDEN NAME OF MOTHER, Delia Stivers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mrs. Geo. B. Loden

(Address) 12 N. Gilmor Street

15- Robert P. Harrison, 192 Registrar.

APR 14 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 13, '23

17- I HEREBY CERTIFY, That I attended deceased from April 7, 19 23 to April 13, 19 23

that I last saw him alive on April 11 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. W. Lehmann M. D.

4/13, 19 23 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
New Cathedral Cem	April 16, 1923
20-UNDERTAKER,	ADDRESS
George J Smith	Northern

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74805

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Eutaw Place ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Friedenwald

(a) RESIDENCE NO. 2319 Eutaw Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Moses Friedenwald

6 DATE OF BIRTH (month, day, and year) Feby 8, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Julius Ashborn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Fannie Solomons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herbert Friedenwald

(Address) 2317 Eutaw Place

15 APR 14 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1923, to April 13, 1923.

that I last saw h[illegible] alive on April 13, 1923.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Julius Friedenwald M. D.

19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	4/15/1923
20 UNDERTAKER David Sondheim	ADDRESS 118-20 W. Mt. Royal Ave.

MARGIN RESERVED FOR INDEXING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74806

CERTIFICATE OF DEATH. 160

D74806

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 Hennemann ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME, Infant Hammel

(Residence in Baltimore: No. 2218 Hennemann St.; .....yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	single

6-DATE OF BIRTH, ... 4 (Month) ..... 14 (Day), 1923 (Year).

7-AGE,	If LESS than 1 day,
.....yrs.....mos.....ds.	....hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Balto. md

PARENTS.

10-NAME OF FATHER, Geo. Fred. Hammel

11-BIRTHPLACE OF FATHER (State or Country). Salisbury md

12-MAIDEN NAME OF MOTHER Mary Agnes McComas

13-BIRTHPLACE OF MOTHER (State or Country). Hancock md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Geo. F. Hammel .....

(Address) ..... 2218 Hennemann Ave .....

15-

Filed APR 14 1923 Rebecca P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April (Month) ..... 14th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I saw h er alive on April 14th 1923

and that death occurred, on the date stated above, at 2.20 A.M.

The CAUSE OF DEATH* was as follows:

.....

..... Atelectasis .....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) ..... congenital weakness .....

..... (Duration).....yrs.....mos.....ds.

(Signed) ..... G. E. Bullton ..... M. D.

4/14/23, 191... (Address) ..... 309 Cameron Bldg .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	Apr. 17 1923
20-UNDERTAKER John Sullivan	ADDRESS 2008 Eutaw

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D74807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74807

CERTIFICATE OF DEATH.

46

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1810 N: Bond St ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rippel

(a) RESIDENCE NO. 1810 N: Bond St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Rippel

6 DATE OF BIRTH (month, day, and year) 2/20/1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	I	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Aug Eberwein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M: Eberle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Rippel

(Address) 1810 N: Bond St

APR 14 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to April 11, 1923,

that I last saw her alive on April 10, 1923,

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Feb. 8/23

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Chas. S. Reese, M. D.

. 19 (Address) 408 S Pot Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Apl 12, 23

20 UNDERTAKER John Ellrich

ADDRESS 2006 Elson

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74808

CERTIFICATE OF DEATH. 101-001

D74808

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Springdale Ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Katherine Martin

(a) RESIDENCE. NO. 3704 Springdale Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 7 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. H. Martin

6 DATE OF BIRTH (month, day, and year) October 17 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Centreville Md Queen Anne

PARENTS

10 NAME OF FATHER John Tilghman Wooters

11 BIRTHPLACE OF FATHER (city or town) Centreville Md (State or country) Queen Anne Co. Md

12 MAIDEN NAME OF MOTHER Kate Arrington Dale

13 BIRTHPLACE OF MOTHER (city or town) Easton (State or country) Talbot Co. Md

14 Informant Miss Nellie Wooters (Sister)
(Address) 201 E 25th St. Balto Md

APR 14 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1923, to April 13, 1923, that I last saw her alive on April 13, 1923, and that death occurred, on the date stated above, at 10 00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lancet, pus, consolidation of lung

(Signed) Chas C Wood, M. D.

, 19 (Address) 1701 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	April 16 1923

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

Burial Permit Clerk.

MARGIN RESERVED FOR PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74809

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 Baltimore St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil C. Zinkand

(a) RESIDENCE NO. 2304 Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Emma Zinkand

6 DATE OF BIRTH (month, day, and year) Mar. 13, 184?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Retired. 50

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Zinkand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emil C. Zinkand

(Address) 2304 Baltimore St.

15 Robert P. Harrison, Registrar

APR 14 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 6: 1923, to Apr 14: 1923, that I last saw him alive on Apr 13 1923, and that death occurred, on the date stated above, at 7-45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) W. H. Peace, M. D.

, 19 (Address) 200 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 16 23
20 UNDERTAKER	ADDRESS
Wm. J. Richardson & Son	North St.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74810

CERTIFICATE OF DEATH.

188-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Isabel Ford St.; yrs., 3 mos. ds.)

(Residence in Baltimore: No. 21 Southern Ave.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
female	white	single

6-DATE OF BIRTH. Nov. 21/1902 (Month) (Day) (Year)

7-AGE. 17 yrs. 4 mos. 24 If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Van Bibber Md.

PARENTS.

10-NAME OF FATHER. Wm B. Ford

11-BIRTHPLACE OF FATHER, (State or Country). Bath Maine

12-MAIDEN NAME OF MOTHER, Mary G. Wroth

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. B. Ford

(Address) 21 Southern Ave.

15- Robert P. Harrison

Filed ..... 192 ..... Registrar.

R 1 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 13/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Fracture and laceration of left leg- loss of blood

Struck by Automobile-Accident

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Sollers (Coroner.) M. D.

4/14 1923 (Address) 308 E. Fourth St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Abingdon. Md. DATE OF BURIAL, Apr. 16 1923

20-UNDERTAKER. W. J. Lickner & Son ADDRESS N. & Pa.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74811

D74811

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1708 Park ave, ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and

2-FULL NAME Infant child (female) Mr & Mrs Wm Dunn.)

(a) RESIDENCE. No. 1708 Park ave, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Apr 14, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Nannie Telghman Birch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Jas H Burch (Address) 1708 Park Ave

15 Filed APR 14 1923 Robert P. Harrison, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 14 Birth to Apr 14 1923, that I last saw her alive on Apr 14 1923, at birth and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 months)

Child lived 2 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No—

What test confirmed diagnosis?

(Signed) C H Haywood, M. D.

(Address) 230 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemtery St Mary's Co.	April 15 1923
20 UNDERTAKER	ADDRESS
Wm Cook,	502 E Fayette

GIN RESERVED FOR STAMPING

WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

D74812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74812

REGISTERED No. C.

1-PLACE OF DEATH Pressman & Appleton sts

CITY OF BALTIMORE (No. Oak Hall Md ST.: 16 WARD) 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Baker

(Residence in Baltimore: No. Oak Hall Pressman & Appleton sts St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, about ....., 18.6.

(Month) (Day) (Year)

7-AGE, 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Western Maryland

9-BIRTHPLACE, (State or Country) Baltimor Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country) Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country) Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Tully

(Address) Oak Hall

15-

Filed ....Robert P. Harrison, 19....

Registrar.

4 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April 13 ....., 1923

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Arteriosclerosis .....

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Cerebral Hemorrhage .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... D. T. Hennessy ..... M. D.

(Coroner.)

April 14, 1923 (Address) 202 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Hanover Pa

DATE OF BURIAL, April 16, 1923

20-UNDERTAKER Wm Cook

ADDRESS 502 North

B.—Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74813

CERTIFICATE OF DEATH.

90

D74813

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 Reservoir St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza V Cameron

(a) RESIDENCE. No. 734 Reservoir ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert H Cameron

6 DATE OF BIRTH (month, day, and year) Jan 5 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Armstrong County Penn

PARENTS

10 NAME OF FATHER George W Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bucks County Penn

12 MAIDEN NAME OF MOTHER Isabella Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Armstrong County Penn

14 Informant Robert H Cameron
(Address) 734 Reservoir St

15 Filed APR 14 1923 Robert F. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 1919.. to April 13, 1923.

that I last saw h.. alive on April 13 1923.

and that death occurred, on the date stated above, at 9:25 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Thrombosis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard McClellan M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rose Banks Calvert County Md.	April 16 1923
20 UNDERTAKER	ADDRESS
Wendell Ruppel & Son	37 S Mon

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Poytheress ✓

74814

D74814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 84 D74814

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL. ST., WARD)

2-FULL NAME Olive Daniel Poytheress Jr.

(a) RESIDENCE NO. 7 Guerrier St. So. Norfolk Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Feb 12 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	4	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U.S. Va

PARENTS

10 NAME OF FATHER Olive D. Poytheress

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Ethel Hackney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) BALTIMORE MD.

15 Filed APR 15 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1923, to Apr. 14, 1923, that I last saw h alive on Apr. 14, 1923, and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor, cerebellar glioma

Symptoms (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Post Operative shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Apr. 14

Was there an autopsy? Partial

What test confirmed diagnosis? Operation

(Signed) A. W. Reinhart M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfork Va — DATE OF BURIAL April 15 1923

20 UNDERTAKER William G Schaeffer — ADDRESS 816 Summit

Spec.—6-9-19—H. P. Co.—1000 Bks.

74815-
D74815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74815

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat St. 28th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Hart

(a) RESIDENCE. No. Mt Hope Retreat St. 28th Ward. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs 0 mos. 0 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Hart -

6 DATE OF BIRTH (month, day, and year) about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	0	0	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work Sp of Salesman -

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer ———

9 BIRTHPLACE (city or town) Phila Pa.
(State or country)

PARENTS

10 NAME OF FATHER Patrick Gallagher

11 BIRTHPLACE OF FATHER (city or town) Donigal
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Sweeny

13 BIRTHPLACE OF MOTHER (city or town) Donigal -
(State or country) Ireland -

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Baltimore

15 FILED APR 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1905, to Apr 14 1923, that I last saw him alive on Apr 14. 1923, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular (Mitral) Disease of Heart

Abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr - Manic Depression Psychosis - (duration) 18 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Mt Hope Retreat

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ———

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phila. Pa.	Apr 14 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74816

CERTIFICATE OF DEATH.

90 D74816

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 E. Balto ST., 6 WARD)

2-FULL NAME Harry Offit

(a) RESIDENCE NO. 2024 E. Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Offit

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ellis Offit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ruth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ben Offit

(Address) 2024 E. Balto St

15 APR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/11, 1923, to 4/13, 1923,

that I last saw h[illegible] alive on 4/13, 1923,

and that death occurred, on the date stated above, at 2308 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Terminal)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension. Chr. Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Zd Zinberg, M. D.

4/13, 1923 (Address) 1826 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Memory Park	April 15 1923

20 UNDERTAKER Jacob Levin, ADDRESS 1439 E. Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74817

90 D74817

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home 5 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Kaufman

(a) RESIDENCE No. 115 Cross Fourth St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Kaufman

6 DATE OF BIRTH (month, day, and year) 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work aldaged

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jack Lewis
(Address) 1439 E Balt St

15 FILED APR 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13 1923

17

I HEREBY CERTIFY, That I attended deceased from April 1st, 1923, to April 13th, 1923, that I last saw her alive on April 12th, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Heart Disease
Arterio-Sclerosis
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L. Wasserman M. D.
4 14 1923 (Address) 30 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	4-15 1923
20 UNDERTAKER	ADDRESS
Jack Lewis 1439	E Balt St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74818

D74818

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Smith

(a) RESIDENCE NO. 2122 Washington Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-12-23

7 AGE — Years — Months — Days — If LESS than 1 day, 4 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baca. Maryland

PARENTS

10 NAME OF FATHER Paul B. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baca, Md.

12 MAIDEN NAME OF MOTHER Irma Formsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baca, Md

14 Informant

(Address) 1317 E. Baca.

15 Filed APR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12 1923

17

I HEREBY CERTIFY, That I attended deceased from 4-12, 1923, to 4-12, 1923.

that I last saw h[illegible] alive on 4-12-2, 1923

and that death occurred, on the date stated above, at 8 P M m.

The CAUSE OF DEATH* was as follows:

Premature birth Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

4-12 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Hebrew Rosedale April 13 1923

20 UNDERTAKER — ADDRESS

Jack Lewis, 1397 E. Baca.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74819 ✓ D74819

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 231 E. North Ave. St. 12 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna Letitia Best

(a) RESIDENCE NO. 231 E. North Ave. St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Perry Best

6 DATE OF BIRTH (month, day, and year): July 10, 1852

7 AGE — Years: 70 Months: 9 Days: 3 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Robert H. W. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annabel Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): .....

14 Informant: Miss Lillian Alice Best
(Address) 231 E. North Ave.

15 Filed APR 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-1, 1922, to 4-13, 1923.

that I last saw HER alive on 4-13, 1923.

and that death occurred, on the date stated above, at 9.00 A. m.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF COLON

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? YES Date of 10-22

Was there an autopsy? No

What test confirmed diagnosis? FINDINGS AT OPER

(Signed) John A. Dorsey M. D.

19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Utica N.Y. — DATE OF BURIAL: Apr 16 23

20 UNDERTAKER: Wm Nicholson & Son — ADDRESS: North St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WARNING—RESERVED FOR BINDING

RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74820

CERTIFICATE OF DEATH.

162

D74820

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Belvidere Ave ST.) (27 WARD)

2-FULL NAME Corbin Herbert Hughes

(a) RESIDENCE NO. 407 Belvidere Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 23 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clarence H Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth E. Peck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Col.

14 Informant Clarence H Hughes (Address) 407 Belvidere Ave

15 APR 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1923, to April 14, 1923, that I last saw him alive on April 14, 1923, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Sepsis

Infection from Nasal Condition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. N. Beasley, M. D.

. 19 (Address) 126 W Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Apr 16 1923
20 UNDERTAKER	ADDRESS
Wm J Flickinger & Sons	North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74821

D74821

CERTIFICATE OF DEATH.

46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 2008 Walbrook Ave. WARD) 15

2-FULL NAME Ida May Cole

(a) RESIDENCE NO. 2008 Walbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Cole

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Harry Ewing

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Martin Cole

(Address) 2008 Walbrook Ave

15 APR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 19 22 to April 14, 19 23.

that I last saw h. alive on April 14, 19 23.

and that death occurred, on the date stated above, at 7 30 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus -

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia -

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W J Gilmore - M. D.

(Address) 6 W Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 16 1923
20 UNDERTAKER	ADDRESS
Wm Fleet & Son	Notkeka

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74822

CERTIFICATE OF DEATH.

X 101-001 D74822

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame Convent St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Nazarea Spross

(Residence in Baltimore: No. Craigville St & Ashland Ave St.; ....yrs., 8 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, October (Month) 28 (Day), 1869 (Year)

7-AGE, 53 yrs. 5 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Churchville Monroe Co N.Y.

PARENTS.

10-NAME OF FATHER, Joseph Spross

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Philomina Haberle

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Nazarea

(Address) Notre Dame Craigville St

15- Filed APR 15 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 13 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April - 11 - 1923, to April - 13 1923, that I saw her alive on April - 13 - 1923, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Double pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

4/14, 1923 (Address) 110 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? White Haven Pa

Former or usual residence N.Y.

19-PLACE OF BURIAL OR REMOVAL, Notch Cliff Md. DATE OF BURIAL, April 16, 1923

20-UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Mc Colloghs ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74823

CERTIFICATE OF DEATH.

129 D74823

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 N. Spring St., 10 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie V. McCollough.

(a) RESIDENCE No. 903 N. Spring St.; WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: William J. McCollough.

6 DATE OF BIRTH (month, day, and year): April 14 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George Woods.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: M.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: William J. McCollough
(Address): 903 N. Spring St.

15 Filed APR 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to April 13, 1923, that I last saw her alive on April 13, 1923 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos ~ ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Edward Corbett, M. D.

, 19 (Address) 1506 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	April 18 1923

20 UNDERTAKER: George J. Routh ADDRESS: 1735 Hanford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74824

CERTIFICATE OF DEATH.

90 D74824

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Marshall ST., 23 WARD)

2-FULL NAME Antonio Agro

(a) RESIDENCE NO. 1102 Marshall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6 1907

7 AGE 15 Years 7 Months 8 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Brella. Italy

PARENTS

10 NAME OF FATHER Michelangelo Agro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Brigida Russo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Michelangelo Agro

(Address) 1102 E. Marshall St

15 FILED APR 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to April 14, 1923.

that I last saw him alive on April 12, 1923

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L Persons, M. D.

April 14, 1923. (Address) Fen Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A A | DATE OF BURIAL: 4/16 1923

20 UNDERTAKER: George J Ruth | ADDRESS: 1735 Harford Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Dr Pearson

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74825

CERTIFICATE OF DEATH.

31 D74825

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 Mt Ave Brooklyn ST. 25 WARD)

2-FULL NAME Emma J Hines

(a) RESIDENCE. NO. 326 Mt Ave Brooklyn ST. Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22nd 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Hines Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Pauline Appel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frank Hines Sr

(Address) 326 Maryland Ave Brooklyn Md

15 Filed APR 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to April 10, 1923

that I last saw her alive on April 10, 1923 and that death occurred, on the date stated above, at 1.20 a m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

about- (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no complication (durstion) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Baltimore Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? She was sent to Sanitarium at Lakewood N.J.

(Signed) R. J. Hardy, M. D.

4/18 1923 (Address) 1202 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	April 16 1923
20 UNDERTAKER	ADDRESS
S Schloman & Son	Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Münch ✓

D74826 HEALTH DEPARTMENT—CITY OF BALTIMORE D74826

CERTIFICATE OF DEATH. 122-002

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 139 S. Bouldin ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Münch

(a) RESIDENCE NO. 139 S. Bouldin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Conrad Münch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Thiem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Emma Münch

(Address) 139 S. Bouldin St.

15 APR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to April 12, 1923, that I last saw him alive on April 11, 1923, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Grippe

Pneumonia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. A. Gerry M. D.

4/14/1923 (Address) 3907 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL April 16 1923

20 UNDERTAKER Leo G. Cook ADDRESS Northern Ford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-alcoholic

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74827

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

44 D74827

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 W Conway ST. 22 WARD)

2-FULL NAME William E. Pearson

(a) RESIDENCE. No. 107 W Conway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A Pearson

6 DATE OF BIRTH (month, day, and year) May 3 - 1852

7 AGE Years	Months	Days	If LESS than 1 day. hrs. or min.
70	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hide & Fur Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Shepard S. Pearson

(Address) 4612 Park Heights Ave

15 APR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1922, to Apr. 13, 1923, that I last saw him alive on Apr. 13, 1923, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus (medullary)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray, Illuminopic, Tube test

(Signed) Jno D Elliott M. D.

(Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	April 16 1923

20 UNDERTAKER	ADDRESS
Chas E Franck	502 Madison E

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74828

CERTIFICATE OF DEATH.

5 31 D74828

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 E. Fairmont ave. WARD) 5

2-FULL NAME William J. Johnson

(a) RESIDENCE. No. 1404 E. Fairmont ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED Laborer
(a) Trade, profession or particular kind of work Bethelem Steel Co.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Jane McGlotten
(Address) 1404 E. Fairmont ave

15 Filed APR 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1923, to Apr 12, 1923, that I last saw h[illegible] alive on Apr 12, 1923, and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite (duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

1 C Minus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Edward Fisher, M. D.

4-14 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	Apr. 15 1923
20 UNDERTAKER	ADDRESS
Chris. H. Johnson	416 N Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74829

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D74829

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. Municipal Tuberculosis Hospital ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hill

(a) RESIDENCE NO. 115 Saldner Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Hampton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia

12 MAIDEN NAME OF MOTHER Margaret Croumbill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 APR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1922, to April 13, 1923,

that I last saw her alive on April 13, 1923,

and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Tuberculous ostaitis of spine (duration) 1 ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dadaglacca, M. D.

4-13-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 16, 1923
20 UNDERTAKER	ADDRESS
Jno. H. Hooper	926 N. Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Eliza Bailey

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D74830

CERTIFICATE OF DEATH.

90 D74830

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bridgely or Mt Winans ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Daily

(Residence in Baltimore: No. Bridgely st St.; ... yrs., ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. Colr

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 7 (Month) (Day), 1867 (Year)

7-AGE, 55 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William Queen

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rose Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Randolph Daily

(Address) Mt Winans

15- Filed APR 15 1923, 191... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1922, to April 8 1923, that I saw her alive on April 8 1923, and that death occurred, on the date stated above, at 11.55 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Arteriosclerosis

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. H. Hall M. D.

..., 191... (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Farmer or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	April 15, 191 3
20-UNDERTAKER	ADDRESS
Wm S Gross Hooper	906 Mowry

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74831

CERTIFICATE OF DEATH. 100-001 D74831

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

2-FULL NAME Hester Brannan

(a) RESIDENCE NO. 1 Corte Alley Hamilton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown mos. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	5	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Conn.

PARENTS

10 NAME OF FATHER A. Brannan

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mattie Service

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill.

14 Informant Hospital Records (Address)

15 APR 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1923, to Apr. 14, 1923.

that I last saw h.e alive on Apr. 14, 1923,

and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia,

Pyo-pneumothorax.

(duration) yrs. mos. 3 5 ds.

CONTRIBUTORY (Secondary) Acute Cordiac Dilatation

(duration) Acute yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of Apr. 4, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fair Mount Cemetery	April 17, 23
20 UNDERTAKER	ADDRESS
William Cook	502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74832

D74832

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Reynolds

(a) RESIDENCE NO. 1516 Halbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 ~~COLOR OR RACE~~: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): April 10 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Agnes Hosp Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Joseph Reynolds 1516 Halbrook Ave

15 Filed ..., 19... ROBERT R. KRAUTER Registrar

APR 15 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1923, to April 14, 1923, that I last saw h[illegible] alive on April 14, 1923, and that death occurred, on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Moses Paulson, M. D.

, 19 (Address) St. Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 4/16 1923

20 UNDERTAKER: [illegible] Cook

ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can bo ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Breech Presentation

Spec—12-23-21—E.B.R.S.—400 Blks.

D74833

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74833

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital, St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Gustav Gollner

(a) Residence No....669 Portland St., St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1858

7-AGE. 64 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Machinist

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Hungary

PARENTS.

10-NAME OF FATHER, John Gollner

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country). Hungary

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country). Hungary

14-(Informant) Municipal Hospital Record

(Address).....

15-Filed APR 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 16 19 23 to April 14 19 23 that I last saw h. im alive on April 13 19 23 and that death occurred, on the date stated above, at 6:40 A.M.

The CAUSE OF DEATH* was as follows:

Uraet Failure

.....(Duration)....yrs. 3 mos.....ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

.....(Duration)....1....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) D. G. McKay M. D.

4-14-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Balto Cemetery	4/16/23 19....
20-UNDERTAKER. Geo Leimbacher & Son	ADDRESS 647 W Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Daniel A Hunt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74834

CERTIFICATE OF DEATH.

129 D74834

REGISTERED No. C74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 N Franklin ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Hattie A Hunt

(Residence in Baltimore: No. 1830 N Franklin St. 59 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, or DIVORCED.~~ (Write the word.) Married

6-DATE OF BIRTH. Oct 16th, 1862 (Month) (Day) (Year)

7-AGE. 60 yrs. 5 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country.) Baltimore Co Md.

PARENTS.

10-NAME OF FATHER. Paul A Simpson

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Hattie Keeley

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo A Hunt

(Address) 1830 N Franklin St

15-

Filed APR 15 1923 ROBERT R. KRAUTER, Registrar.

~~Burial Permit to Work.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 13, 1923 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from April 10th 1923, to April 13th 1923, that I saw h[illegible] alive on April 12 1923, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 4 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 2 yrs. mos. ds.

(Signed) Geo W Malcolm M. D.

April 13, 1923 (Address) 1300 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem

DATE OF BURIAL. April 16 1923

20-UNDERTAKER Geo A Imley Sutton

ADDRESS Lafayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74835 ✓ D74835

CERTIFICATE OF DEATH.

51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Norman ave St., W. WARD)

2-FULL NAME Thomas E Merryman

(a) RESIDENCE NO. 403 Norman ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora E Merryman

6 DATE OF BIRTH (month, day, and year): May 5th 1880

7 AGE: Years 42 Months 11 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md.

PARENTS

10 NAME OF FATHER: Thomas Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Ruth Manley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md.

14 Informant: ~~Dora~~ Dora Merryman

(Address): 403 Norman Ave

15 Filed APR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 27 1923 to April 12 1923.

that I last saw him alive on April 12, 1923,

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Ulcerative)

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) J Mack Thomas M. D.

(Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: April 16 1923

20 UNDERTAKER: Robt F Turner Inc

ADDRESS 1442 E Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

D74836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74836

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Welsh

(a) Residence No. 1224 S. Clinton St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of single

6-DATE OF BIRTH (month, day and year) Jan 21st/1888

7-AGE. 35 ? yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto? Md

PARENTS.

10-NAME OF FATHER, Patrick Welsh

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland?

12-MAIDEN NAME OF MOTHER, Bridget Cuolly?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed APR 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 13, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1923 to April 13, 1923

that I last saw him alive on April 12, 1923

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis,

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Chemical

(Signed) J. A. McCoy M. D.

4-13-1923 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Patrick	April 16, 1923
20-UNDERTAKER Prof. J. Turner Inc	ADDRESS 1442 N. Broadway

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74837

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 W. Lombard ST. 19 WARD)

2-FULL NAME William C. Rumney

(a) RESIDENCE NO. 1312 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ida L Rumney

6 DATE OF BIRTH (month, day, and year) Jan 18-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46	–	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Chas H Rumney

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Luther

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Charles T Rumney (Address) 1312 W Lombard St

15 APR 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to April 13, 1923, that I last saw him alive on April 13, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteric Sclerosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical ex

(Signed) J. M. Lumpkin, M. D.

April 15 1923 (Address) 826 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	4-16-1923
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Hollins Sts

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74838

CERTIFICATE OF DEATH. X 49 D74838

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Camp Holabird, Md. ST.: 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma C. Witherell

(a) RESIDENCE. No. Camp Holabird, Md. ST., WARD. Maine
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Witherell

6 DATE OF BIRTH (month, day, and year) Nov 21, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fayette
(State or country) Maine

PARENTS

10 NAME OF FATHER Louis Belanger

11 BIRTHPLACE OF FATHER (city or town) Quebec
(State or country) Canada

12 MAIDEN NAME OF MOTHER Harriett Erskine

13 BIRTHPLACE OF MOTHER (city or town) Fayette
(State or country) Maine

14 Informant Major Carl H. Witherell
(Address) Camp Holabird Md.

15 FILED APR 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20th, 1923, to April 13th, 1923, that I last saw her alive on April 13th, 1923, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the lung.

(duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Malignant cells in Pleuritic effusion

(Signed) Edwin R. Strong, M. D.

, 19 (Address) Camp Holabird, Md. Capt. M. C. U. S. A.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Land, Maine	4/15th 1923
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltoh.

PRINTED PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74839

CERTIFICATE OF DEATH. 22-002 D74839

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily A. Hunter

(Residence in Baltimore: No. Washington DC. St.; yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Married

6-DATE OF BIRTH. Apr. 7 1897
(Month) (Day) (Year)

7-AGE. 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Washington DC

PARENTS.

10-NAME OF FATHER, Joe Redwood

11-BIRTHPLACE OF FATHER, (State or Country): Washington D

12-MAIDEN NAME OF MOTHER, Cecia Redwood

13-BIRTHPLACE OF MOTHER, (State or Country): Washington D C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt A Hunter

(Address) Washington DC

15. Filed APR 15 1923, 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 14 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis & Cirrhosis of Liver

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

Apr. 15 1923. (Address) 16 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 1 day In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Washington DC	4/15 1923
20-UNDERTAKER.	ADDRESS
Geo J Smith	1532 Bolton W

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks ..... a .....

Non-alcoholic

.....

.....

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hemorrhage, Gangrene, Gastritis, Erysipelas, Meningitis, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyemia, Septicemia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

74839

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74840

162922 Surg D74840

CERTIFICATE OF DEATH.

X 49

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Reed Boylston

(a) RESIDENCE NO. Newberry S.C. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 986

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Press F. Boylston

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Mary Crum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed APR 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12 1923 to April 14 1923, that I last saw him alive on April 14 1923, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Brain tumor, right dural endothelioma

about (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Apr. 14

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) W. E. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newberry, South Carolina

DATE OF BURIAL 4/14/23

20 UNDERTAKER W E Hughes

ADDRESS 432 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74841

CERTIFICATE OF DEATH.

74-001

D74841

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 5715 Harford Rd St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edna M Myers

(a) Residence No.... 5715 Harford Rd St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edna A Myers

6-DATE OF BIRTH (month, day and year) April 3 1886

7-AGE, 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn Buggies

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas A Myers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Clara E Potter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Edna A Myers

(Address) 5715 Harford Rd

15- APR 16 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 15 1923

17- I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 15, 1923, that I last saw h[illegible] alive on April 14, 1923, and that death occurred, on the date stated above, at 5 03 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral

(Duration) yrs. 7 mos. 7 days

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. 7 mos. 7 days

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. A. Long M. D.

Apr. 15, 1923 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood — DATE OF BURIAL, April 17 1923

20-UNDERTAKER, William Cahsin & Nattan — ADDRESS

Long man Nattan.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74842 HEALTH DEPARTMENT—CITY OF BALTIMORE D74842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 137 Calvin St. St., 5 Ward)

Registered No. C. 91-002

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Robinson

(Residence in Baltimore: No. 137 Calvin St. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

6-DATE OF BIRTH, Mar. 4 1820
(Month) (Day) (Year)

7-AGE, 103 yrs. 1 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: white
(b) General nature of Industry, business, or establishment in which employed (or employer): washer

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country) unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Taylor

(Address) 165 Calvin St.

15- Filed APR 16 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 13 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Edema

Bronchopneumonia (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. Reed M. D.

Apr 15 1923 (Coroner.) (Address) 165 Calvin St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cem. DATE OF BURIAL, Apr. 17 1923

20-UNDERTAKER, Chas. N. Johnson ADDRESS 416 N. St. Caroline

Spec—12-23-21—E.B.R.S.—400 Blks.

D74843

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ D74843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2213 N. Baltimore St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard E. Krause

(a) Residence No. 2213 N. Baltimore St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: ~~Female~~ Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) apr. 23. 1893

7-AGE, 29 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto, md.

PARENTS.

10-NAME OF FATHER, Wm. F. Krause

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Catherine E.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

11- (Informant) Catherine E. Krause

(Address) 2213 N. Balto St.

15- Filed APR 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 13/23

17- I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to April 13, 1923, that I last saw him alive on April 13, 1923, and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical ex

(Signed) J. M. Lumpkin M. D.

, 19 (Address) 926 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge

DATE OF BURIAL, Apr. 16, 1923

20-UNDERTAKER. John Ouellich

ADDRESS 1201 N. Fayette St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74844

HEALTH DEPARTMENT—CITY OF BALTIMORE

12-D74844

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2002 Plymouth Ave (WARD) 13

2-FULL NAME Margret A Worden

(a) RESIDENCE NO. 2002 Plymouth Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Worden

6 DATE OF BIRTH (month, day, and year) March 5 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Peter Parker

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Susan Woods

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Information given by George Worden (Address) 2002 Plymouth Ave

15 Filed APR 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1923 to April 14th, 1923, that I last saw h alive on April 14th, 1923 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows: (a) Acute Cardiac Dilation

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Edema

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms

(Signed) W. H. Tilcut, M. D.

(Address) 1717 Mercer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mays Chapel Bulto Co	April 17 1923
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Lemke

D74845

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74845

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 N Eutaw St. 20 WARD)

2-FULL NAME Susanna Lemke.

(a) RESIDENCE. NO 1123 Hollins ST., 18 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow 1863

6 DATE OF BIRTH (month, day, and year) Feb 13 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Peter Zeffler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Fadum

(Address) 435 N Eutaw St

15 APR 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/23. 19

17 I HEREBY CERTIFY, That I attended deceased from 1/25/23, 19..., to 4/13/23, 19..., that I last saw h.. alive on 4/13/23. 19..., and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

Chr. Lob Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs 7 mos. 15 ds.

18 Where was disease contracted if not at place of death? 1123 Hollins

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. W. Wood, M. D.

4/14, 1923 (Address) 1302 E Fort

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	April 17 1923

20 UNDERTAKER ADDRESS

John J. Fields 1200 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74846

CERTIFICATE OF DEATH.

V 74-001 D74846

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 1543 Clifton av ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A Zimmerman

(a) RESIDENCE. No. 1543 Clifton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mail	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 21 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	8	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Police
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 161

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Zimmerman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Daughter
(Address) 1543 Clifton Av

15 Filed APR 16 1923 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1923, to April 14, 1923, that I last saw him alive on April 14, 1923, and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred D Jewett, M. D.

, 19 (Address) 2476 Penn av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	April 17 19

20 UNDERTAKER John Fotheldo ADDRESS 1200 W Fayette

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Torran

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74847

D74847

32

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lewis Torran

(a) Residence No. 510 Bruce St. St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1904

7-AGE.	If LESS than 1 day,
18 ? yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ?

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Va.

PARENTS.

10-NAME OF FATHER, Eph. Torran

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va.

12-MAIDEN NAME OF MOTHER, Nannie Hall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va.

14-

(Informant) Municipal Hospital Records

(Address).....

15-Filed APR 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 10, 19 23 to April 12 19 23

that I last saw h. im alive on April 12 19 23

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. McKay M. D.

4-13-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Apr. 16, 23
20-UNDERTAKER.	ADDRESS
Wm. H. Case Son	1400 Mosher

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D74848

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Poplar & Cedar Ave St. Mary's 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles P. Horstman.

(a) RESIDENCE NO. Poplar & Cedar Ave Overlea WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) October 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	56	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 615

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James D. Horstman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Cardlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Anna Beatty (Address) Overlea Md.

15 ROBERT R. KRAUTER. APR 16 1923 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/12/23. 19..., to 4/13/23. 19..., that I last saw him alive on 4/13/23, 19..., and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. A. Post, M. D.

4/13, 1923 (Address) Overlea

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	April 16 1923
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74849

D74849

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1321 N. Caroline St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Miles

(Residence in Baltimore: No. 1321 N. Caroline St.; yrs., 75 mos., -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Do not know ..... 1..... (Month) (Day) (Year)

7-AGE. About 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Litz

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clara M. Bannan

(Address) 1321 N. Caroline St.

15- Filed APR 16 1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 14 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chronic Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza (1918)

(Duration) ..... mos. ..... ds.

(Signed) J. S. P. Collier M. D.
(Coroner.)

4 15 1923 (Address) 106 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cemetery	4/17, 1923

20-UNDERTAKER,	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec.—1-10-21—M&T—1500 Blks.

D74850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D74850

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 E. 42d. ST., 9 WARD)

2-FULL NAME William Marcellus Burgan

(a) RESIDENCE No. 508 E. 42d ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Katherine Emrich

6 DATE OF BIRTH (month, day, and year) Oct. 26, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Lumber

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Philip Burgan

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Brady

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Anna Katherine Burgan (Address) 509 E. 42d. St.

15 Filed APR 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1923

17

I HEREBY CERTIFY, That I attended deceased from April 4 1923, to April 14 1923, that I last saw him alive on April 13 1923, and that death occurred, on the date stated above, at 4.55 a m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jeffries Buell, M. D.

4/14, 1923 (Address) 1516 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/16 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D74851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D74851

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3207 Independent St. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Gannon Jr.

(Residence in Baltimore: No. 3207 Independent St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	white	single

6-DATE OF BIRTH, July 15/1892 (Month) (Day) (Year)

7-AGE. 30 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. John J. Gannon

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Delia M. Mahoney

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) JohnJ.Gannon

(Address) EXFU 3207 Independent

15- Filed APR 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilitation- Probably Valvular Insuffiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma for yrs.

(Duration) yrs. mos. ds.

(Signed) J S H Coleman M. D. (Coroner.)

4/15/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	April 17 1923
20-UNDERTAKER.	ADDRESS
Henry Hoech Son	1501 E Eager St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74852

D74852

CERTIFICATE OF DEATH.

74001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 304 Belvedere St. 57 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ryan

(a) RESIDENCE. No. 304 Belvedere Av WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Ryan

6 DATE OF BIRTH (month, day, and year) — — 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portland Maine

PARENTS

10 NAME OF FATHER Stephen Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Bellinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portland Maine

14 Informant Mary Ryan

(Address) 304 Belvedere

15 Filed APR 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1923

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to April 14, 1923, that I last saw him alive on April 13, 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Analysis (Auto-intoxication) Hemorrhage into Cortical.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. H. Buckley, M. D.

, 19 (Address) 2600 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville	4/17 1923

20 UNDERTAKER Martin J. Mayhood ADDRESS 1811 W. Fayette St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE WITH PEN AND INDELIBLE INK

Spec.—1-10-21—M&T—1500 Bks.

D74853

HEALTH DEPARTMENT—CITY OF BALTIMORE D74853

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Ashburton av ST., 20 WARD)

2-FULL NAME Gardner Linn George

(a) RESIDENCE NO. 12 ashburton ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 19 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 27 1923

7 AGE — Years — Months 19 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Gardner George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ethel Reibert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Gardner George
(Address) No. 12 Ashburton Ave;

15 APR 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 31, 1923, to April 15, 1923, that I last saw him alive on April 14, 1923, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Jaundice. (since birth)
(Baby was a 5 month Premature)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Walter E. Luckenger M. D.

April 15 1923 (Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL April 16, 1923

20 UNDERTAKER L. N. Dill — ADDRESS 3109 Fredk Ave;

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74854

CERTIFICATE OF DEATH.

47 D74854

1-PLACE OF DEATH Howard A Kelly Hospital
CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.: 14 WARD)
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edith T. Alexander

(a) RESIDENCE. NO. Robinson Ill ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Alexander

6 DATE OF BIRTH (month, day, and year) April 13 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Robinson Ill.
(State or country)

PARENTS

10 NAME OF FATHER John H. Taylor
11 BIRTHPLACE OF FATHER (city or town) Columbus
(State or country) Ohio
12 MAIDEN NAME OF MOTHER Grace Elmira Vernon
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio

14 Informant Joseph Vernon Alexander
(Address) 2079 King st Robinson Ill.

15 Filed ..., 19 ...
Registrar
APR 16 1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17
I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to April 16, 1923, that I last saw h[illegible] alive on April 12, 1923, and that death occurred, on the date stated above, at 2 30 a.m.

The CAUSE OF DEATH* was as follows:
Bronchio pneumonia

(duration) ... yrs. ... mos. 5 ds.
CONTRIBUTORY (Secondary) Recurrent Carcinoma Breast
(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1337 Ket Royal Ave
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical exam.

(Signed) Arthur J Brennan, M. D.
4/16 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Robinson Ill	April 17 1923

20 UNDERTAKER ADDRESS
Chas. G. Black 1472 W. Northern

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D74855

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 913 Plum Al. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Watts.(C). 30 ----------.

(Residence in Baltimore: No. 913 Plum Al. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. Do not know. ....., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
51 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Calvert Co Md.

PARENTS.

10-NAME OF FATHER. Caesar Watts.(C).

11-BIRTHPLACE OF FATHER, (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Riley.(C)(sister).

(Address) 34 E. Hughes St.

15- FILED APR 16 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 13, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Apr. 16, 1923. (Address) 1017 E. Charles St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	April 16 1923
20-UNDERTAKER.	ADDRESS
J. L. Brown & Son	1018 W. Mulberry St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D74856 HEALTH DEPARTMENT—CITY OF BALTIMORE D74856

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 126 W. Perry St. St., 22 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha R. Green. (C).

(Residence in Baltimore: No. 126 W. Perry St. St.; yrs., 17 -- mos., 11 -- ds., 5.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH. May 8, 1905. (Month) (Day) (Year)

7-AGE. 17 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Easton Md.

PARENTS.

10-NAME OF FATHER. James Green. (C).

11-BIRTHPLACE OF FATHER, (State or Country). Easton Md.

12-MAIDEN NAME OF MOTHER. Goerganna Gould. (C).

13-BIRTHPLACE OF MOTHER, (State or Country). Easton Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Green. (C). (father).

(Address) 517 W. Barre St.

15- Filed APR 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 13, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Hoff M. Rossmassler M. D.
(Coroner)

Apr. 16, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cet	April 16 1923
20-UNDERTAKER.	ADDRESS
J. L. Braun & Son	1084 Madison St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74857

CERTIFICATE OF DEATH.

74-001 D74857

REGISTERED NO.

1-PLACE OF DEATH 724 North Broadway

C. OF BALTIMORE: (No. 724 N. Broadway ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Johnson

(a) RESIDENCE NO. 724 N. Broadway ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~(Husband of)~~ (or) WIFE OF Frank Johnson

6 DATE OF BIRTH (month, day, and year) May 15, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Seaford Del.

PARENTS

10 NAME OF FATHER Alfred DeJay

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Emelia Colburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Chas. Colbourn

(Address) 724 N. Broadway

15 Filed APR 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to April 13, 1923

that I last saw her alive on April 13, 1923

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Visual Exam

(Signed) C. H. Broadmeadow, M. D.

April 13 1923 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	April 17 1923
20 UNDERTAKER Philip Herring	ADDRESS 2016 Aliceanna

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74858

CERTIFICATE OF DEATH.

D74858

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2135 Druid Hill Ave ST., 94 WARD)

2-FULL NAME Agnes Adams

(a) RESIDENCE NO. 2135 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): /

(c) Name of employer: /

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Littleton Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sylvia Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Harry Holmes

(Address) 2135 Druid Hill Ave

15 APR 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/14 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/7, 19 23, to 4/14, 19 23,

that I last saw her alive on 4/14, 19 23,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy + Paralysis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Robt Griffith, M. D.

1923 (Address) 2135 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr 16 1923
20 UNDERTAKER: Jno. H. Tradin	ADDRESS 142 Uniontown

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74859

CERTIFICATE OF DEATH.

159-002 D74859

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Riverside ST. 24 WARD)

2-FULL NAME Hazel Irma Spurrier

(a) RESIDENCE NO. 1411 Riverside ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-16-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Gilbert Spurrier

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elsie Brown

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co.
(State or country)

14 Informant Mrs. S. Spurrier
(Address)

15 Filed APR 16 1923 ROBERT H. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 16, 1923, that I last saw her alive on April 16, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Convulsions & Patent. foramen Ovale

(duration) ..... yrs. ..... mos. 6 hrs. ..... ds.

CONTRIBUTORY —
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edward Lynch M. D.

4/16 1923 (Address) 16 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk

DATE OF BURIAL 4/16 1923

20 UNDERTAKER J. Few McCully

ADDRESS 130 E. Front

INFORMATION, WITH PENDING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D74860

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D74860

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Vincents Infrary.

CITY OF BALTIMORE: (No. 1401- division ST., 14 WARD)

2-FULL NAME Charles Thomas

(a) RESIDENCE No. 14 1/2 Chesapeake ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) March 26th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	X	XI	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Lee

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Louise Thomas

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va.

14 Informant Louise Thomas (Address) 1401 Chesapeake St.

15 Received APR 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 20, 1923, to April 15, 1923.

that I last saw him alive on April 14, 1923

and that death occurred, on the date stated above, at 7 00 a m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) ..... yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas. R. Goldborough, M. D.

, 19 (Address) 2935 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ca Funeral

DATE OF BURIAL 4/17/ 1923

20 UNDERTAKER Martin Fahey Sons

ADDRESS Baltimore

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74861

CERTIFICATE OF DEATH.

66 D74861

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 So. Ann ST., 2 WARD)

2-FULL NAME THOMAS GARDYAN,

(a) RESIDENCE NO. 300 So. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 33 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maggie Gardyan,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wire Worker,

(b) General nature of industry, business, or establishment in which employed (or employer) at home,

(c) Name of employer

9 BIRTHPLACE (city or town) Ausrtia,
(State or country) Poland,

PARENTS

10 NAME OF FATHER Thomas Gardyan,

11 BIRTHPLACE OF FATHER (city or town) Austria,
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) Austria,
(State or country) Poland,

14 Informant Thos. J. Gardyan Jr.
(Address) 300 So. Ann Street

15 Filed APR 16 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1923, to April 13, 1923, that I last saw h[illegible] alive on April 13, 1923, and that death occurred, on the date stated above, at 11.56 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Lesion of heart

Acute Pleurisy (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine 6, M. D.

April 14, 1923 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	April 17. 1923.
20 UNDERTAKER	ADDRESS
W F Sadowski.	705 S. Ann St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Alcoholism

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D74862

CERTIFICATE OF DEATH.

D74862

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Leadenhall St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Robb.

(a) RESIDENCE. No. 902 Leadenhall St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Cousmore Robb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Va

12 MAIDEN NAME OF MOTHER Virginia Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Mother Virginia Robb

15 Filed 19 Registrar

APR 16 1923 ROBERT R. KRAUTER Burial Permit Clerk.

APR 16 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 15, 1923, that I last saw her alive on April 15, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Stanley W Matthews, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn.	4. 17 1923
20 UNDERTAKER	ADDRESS
R L Parham	220 W Hamburg St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D74863

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Park Ave ST. 14 WARD)

2-FULL NAME Mary Elizabeth Bosley

(a) RESIDENCE. No. 1403 Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William H. Bosley

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X	68	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto County Maryland

PARENTS

10 NAME OF FATHER Robert Cockey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER ------- Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Maryland

14 Informant (Address) George H. Crook 1008 Cathedral St

15 Filed APR 16 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-23 19

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10, 19 22, to Apr 15, 19 23

that I last saw h alive on Apr. 15, 19 23

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Carcinoma

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical + X ray.

(Signed) George H. Crook, M. D.

, 19 (Address) 1008 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	4/17 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74864

CERTIFICATE OF DEATH.

161-001 D74864

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N. Rose ST.: 6 WARD)

2-FULL NAME Mary M. Doyle.

(a) RESIDENCE. No. 215 N. Rose ST., 6 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John H. B. Doyle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Marie Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John H. B. Doyle
(Address) 215 N. Rose St.

15 Filed APR 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-5, 1923, to 4-14 1923, that I last saw h[illegible] alive on 4-13 1923 and that death occurred, on the date stated above, at 0536 M.

The CAUSE OF DEATH* was as follows:

Premature Birth
Hours: 7 ctes
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) [illegible] M. D.

19 (Address) 500 N. Bath St. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	April 16 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 N. Wolfe St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Weir ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74865

D74865

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 702½ Rebecca ST.: 4 WARD)

2-FULL NAME Edward F Weir

(a) RESIDENCE. No. 706½ Rebecca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: D. Otis

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Stefan Weir

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Mrs John Kear 706½ Rebecca st

15 Filed APR 16 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12 1923 to April 14 1923 that I last saw h[illegible] alive on April 14 1923 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Do Anemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. B. Horsley M. D.

(Address) 712 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Anthurn Cemetery	April 17 1923

20 UNDERTAKER: Jno Ge Hoffman ADDRESS: 406 W. Baltimore St

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

16r670 D74866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X/35 D74866

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Cook

(a) RESIDENCE No. Titusville, Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 25 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 FILED APR 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to April 16, 1923, that I last saw him alive on April 16, 1923 and that death occurred, on the date stated above, at 7.25 A. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 3 yrs. 1/2 mos ... ds.

CONTRIBUTORY (Secondary) Septic Cystitis (Staphylococcus)

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of April 11, 1923

Was there an autopsy? no

What test confirmed diagnosis? Blood Culture

(Signed) Eugene C. Shane, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Titusville Pa	April 1923
20 UNDERTAKER	ADDRESS
Gee M. Prindle & Son	Titusville Pa

MAKE ONE ENTRY ONLY IN EACH SPACE—WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74867

74-001 D74867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 615 S. Ann's St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Louise Sinclair

(a) RESIDENCE No. 615 S. Ann's St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 WHETHER Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas H. Sinclair

6 DATE OF BIRTH (month, day, and year) Jan. 7-1859

7 AGE Years 64 Months 3 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Wehn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Leutown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Grace Becker

(Address) 615 S. Ann's St.

Filed Apr 16 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) April (day) 15th (year) 1923

17 I HEREBY CERTIFY, That I attended deceased from April 9th, 1923, to April 15th, 1923.

That I last saw him alive on April 15th, 1923, and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1X mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) Jno Washington Troy Jr M.D.

4/16/23 (Address) John Washington Troy Jr M.D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 18 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

162269
D74868

HEALTH DEPARTMENT—CITY OF BALTIMORE D74868

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 1 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Denniston Jr.

(a) RESIDENCE No. 832 S. Luzerne St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. — mos. — ds. How long in U. S., if of foreign birth? 14yrs yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~or) WIFE of~~ George & Mary Denniston (Parents)

6 DATE OF BIRTH (month, day, and year) April 6, 1909.

7 AGE: Years 14 | Months (4) | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): (")
(c) Name of employer: (")

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS
10 NAME OF FATHER: George Denniston
11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland
12 MAIDEN NAME OF MOTHER: Mary
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address) Records

15 Robert F. [illegible]
19 Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1923, to April 14, 1923.
That I last saw h[illegible] alive on April 14, 1923,
and that death occurred, on the date stated above, at 7.32 A.m.

The CAUSE OF DEATH* was as follows:
Rheumatic Fever (Acute)
Chronic Endocarditis

(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bacterial Endocarditis
Acute Nephritis 2? mos.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? yes.
What test confirmed diagnosis? Autopsy.
(Signed) Horton Casparis, M. D.
19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Casimir Slavs Cem
DATE OF BURIAL: April 17 1923

20 UNDERTAKER: Stephen J. Galkowski
ADDRESS: [illegible]

mation should be carefully supplied. AGE al
CAUSE OF DEATH in plain terms, so that it n
TION is very important. See instructions on b
of certificates.

16 1923

Spec. 1-1923 MAT 1500 Blks.

D74869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74869

CERTIFICATE OF DEATH.

X38

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene St., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isiah Abram

(a) RESIDENCE NO. Davidsonville Md St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jim Abram

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Scott Abram Davidsonville Md

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/24, 1923, to 4/7, 1923, that I last saw h alive on 4/7, 1923, and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Rupture Aneurysm of Ascending and Aorta Arches

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Outside

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Leon. Friedman, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND,

DATE OF BURIAL: APR 14 1923

20 UNDERTAKER Commissioner Health,

per Wm. E. WOODALL

Registrar [illegible] Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D74870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74870

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Edward Gorum.....

(a) Residence No. Bay View Hospital. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, John Gorum

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, Milley Gorum

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address)..... UNIVERSITY OF MARYLAND

15- Robert P. Harrison, Registrar.

APR 6 1923 192.....

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 9, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 29, 1923 to April 9, 1923

that I last saw him alive on April 9, 1923

and that death occurred, on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 15 ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) J. A. Mucka M. D.

4-10-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND

DATE OF BURIAL, ... 19....

20-UNDERTAKER. Commissioner Health,

ADDRESS APR 16 1923

Per, Wm. E. WOODALL.

APR 14 1923

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form—12-23-21—E.B.P.S.—400 Blks.

D74871

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74871

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James N. Carlin

(a) Residence No. 221 Alice Ann St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE.	If LESS than 1 day.
48 yrs. ... mos. ... ds.	... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Patrick Carlin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Bertie Gillanders

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed ... Robert F. Harrison, Registrar.

8/16/1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 10, 1923

17- I HEREBY CERTIFY, That I attended deceased from January 31, 19 23, to April 10, 19 23, that I last saw him alive on April 10, 19 23, and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Died because due to aortic insufficiency

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) 20 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Mccoy M. D.

4-11-19 23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND

DATE OF BURIAL, ... 19....

20-UNDERTAKER. Commissioner Health.

ADDRESS APR 14 1923

Per. Wm. E. WOODALL.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

D74872

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 4161-081

County D74872

Village or City (No. 1646 Fort Ave St: 24 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Baby Beuesch

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Wht | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Sngl

6 DATE OF BIRTH April 11, 23 (Month) (Day) (Year)

7 AGE ... yrs. ... mos. 1 ds. | If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9 BIRTHPLACE (State or country) Baltimore

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER Mary Bauch

13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christine Beuesch
(Address) 914 S Luzerne Ave

15 Robert F. Harrison, M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 13, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1923 to April 13, 1923 that I last saw h[illegible] alive on April 12, 1923 and that death occurred on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) William H. Lynch, M. D.

April 13, 1923 (Address) 814 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL UNIVERSITY OF MARYLAND. | DATE OF BURIAL ..., 191

20 UNDERTAKER Commissioner Health | ADDRESS

Per. Wm. E. WOODALL.

APR 14 1923

Burial blanks are needed; address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. [illegible]

APR 16 1923

Local Registrar Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74873

161-001

D74873

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1109 Appleman Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Mrs.) Silvia

(Residence in Baltimore: No. 1109 Appleman Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

6-DATE OF BIRTH: Apr (Month) 9 (Day) 1923 (Year)

7-AGE: 15 mos. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: ---
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Constant Silvia

11-BIRTHPLACE OF FATHER, (State or Country), Cape Verde Island

12-MAIDEN NAME OF MOTHER, Alice Perry

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie White

(Address) 1107 Appleman Ave

15-

Filed ..... 19.. Registrar.

Robert P. Garrison,

Burial Permit Clerk.

1 6 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 hrs. 2 minutes Duration

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) unknown

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Baker M. D.
(Coroner.)

4/11 1923 (Address) 105 E. Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ... 19..

JOHNS HOPKINS HOSPITAL

20-UNDERTAKER, Commissioner Health, ADDRESS

APR 14 1923

20. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74874

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74874

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 N. Lakewood ave ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Spero

(a) RESIDENCE NO. 134 N. Lakewood ave ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1st

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Alphonso Spero

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Agnes Blank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Alphonso Spero

(Address) 134 N. Lakewood

15 Robert L. Harrison, Registrar

, 19

Burial Permit Clerk

R 161923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 16, 1923, that I last saw h[illegible]ive on April 16, 1923, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

1

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Maxwell Emanuel M. D.

4/16, 1923 (Address) 315 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cem.	4/16 1923
20 UNDERTAKER J. A. Moan	ADDRESS 3000 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74875

CERTIFICATE OF DEATH.

74-001

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Washington Street ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME PAULINE SINGEWALD

(a) RESIDENCE. No. 5 N. Washington Street ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. — mos. — ds. How long in U. S., if of foreign birth? 84 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of TRAUGOTT H. SINGEWALD

6 DATE OF BIRTH (month, day, and year) April 12, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	0	3	

8 OCCUPATION OF DECEASED retired

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Muehltroff, Saxony, Germany

PARENTS

10 NAME OF FATHER JOHANN WOLFRAM

11 BIRTHPLACE OF FATHER (city or town) (State or country) Saxony, Germany

12 MAIDEN NAME OF MOTHER CHRISTIANNA Kniepser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Saxony, Germany

14 Informant (Address) EDW. M. SINGEWALD 5 N. Washington Street

15 Filed ....., 19 Robert E. Barrick, Registrar

16 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16th, 1921, to April 15th, 1923, that I last saw her alive on April 15th, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

General Arterio-sclerosis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. 21 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Singewald, M. D.

4/15, 1923 (Address) 5 N. Washington Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dove Meemann	April 17 1923
20 UNDERTAKER Lorraine Corp	ADDRESS 32 N Broad

Information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74876

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3914 Fait Ave. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Schlee.

(a) RESIDENCE NO. 3914 Fait Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Henry Schlee.

6 DATE OF BIRTH (month, day, and year) June 20-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Schlee. (Son)

(Address) 351 S Poppe St.

15 Filed 1923 Robert P. Harrison. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 1923, to Apr 13, 1923, that I last saw her alive on Apr 10, 1923, and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By Examination

(Signed) Geo Clinton Blades, M. D.

, 19 (Address) 1436 Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL April 19 1923.

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 E Wolfe St.

16 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74877

CERTIFICATE OF DEATH.

X 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma M. Hubble.

(a) RESIDENCE NO. 709 Light ST., WARD Tampa Fla.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) april 14-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Tampa. Fla.

PARENTS

10 NAME OF FATHER L L. Hubble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.

12 MAIDEN NAME OF MOTHER Imogen Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) R.I.

14 Informant (Address) Sydenham Hosp.

15 [illegible] 19 Registrar

Robert P. Garrison,
Burial Permit Clerk.

R 16 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 16 1923

17 I HEREBY CERTIFY, That I attended deceased from april 15, 1923, to april 16, 1923, that I last saw her alive on april 15, 1923, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, Laryngeal & pharyngeal.

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) [illegible], M. D.

4/16/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL April 16 1923

20 UNDERTAKER John F Dorsey — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74878

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Edmondson Ave 19 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lotta Adelaide Smyrk

(a) RESIDENCE NO. 1513 Edmondson Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. F. Smyrk

6 DATE OF BIRTH (month, day, and year) Aug 28, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. F. Deacon

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emma Joyner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Wm. F. Smyrk 1513 Edmondson Ave

15 Filed APR 16 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17

I HEREBY CERTIFY, That I attended deceased from April 1st, 1923, to April 14th, 1923.

that I last saw her alive on April 14th, 1923.

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows: Bilateral Lobar Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Page Edmunds, M. D.

4/16, 1923 (Address) 605 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sutcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 4/17 1923

20 UNDERTAKER Wm. J. McCausland

ADDRESS North Ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74879

HEALTH DEPARTMENT—CITY OF BALTIMORE D74879

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3011 Clifton ST.: ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mally F. Peakley

(a) RESIDENCE. No. 3011 Clifton Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widower of Frederick S. Peakley

6 DATE OF BIRTH (month, day, and year): March 15, 1851

7 AGE: Years 72; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Frederick S. Peakley 3011 Clifton Ave

15 Filed: R 16 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 18, 1923, to Apr. 14, 1923, that I last saw her alive on Apr 14, 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Senile) with arrhythmia and gradual failure

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Terminal Cerebral Hem. (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Records

(Signed) Wesley Cole, M. D.

4/15 1923 (Address) 220 Gramercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Apr 17 1923

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74880

D74880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 7

CITY OF BALTIMORE: (No. 2122 Brook St, ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Riegel

(a) RESIDENCE No. 2122 Brook 11 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 1919 or 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER John E. Riegel

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Ida Taylor

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Ida Riegel

(Address) 2122 Brook

15 Filed Robert P. Harrison, Registrar

APR 16 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 '23

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to April 16, 1923.

that I last saw h- alive on April 15, 1923.

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hunter Bailey, M. D.

(Address) 2938 S Sharp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	April 18 1923
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

D74881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Asbury Graves

(a) RESIDENCE NO. Stevensville Md St., WARD Stevensville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. J. A. Sellman

(Address) Stevensville, Md

15 Filed Robert P. Harrison, Registrar

APR 16 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 1923

17

I HEREBY CERTIFY, That I attended deceased from 4/13, 1923, to 4/14, 1923, that I last saw h alive on 4/14, 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Thos Fordham, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL April 17 1923

20 UNDERTAKER E. Schlomanson ADDRESS 1037 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74882

CERTIFICATE OF DEATH.

100-001 D74882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 N Patterson Park Ave ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Dietz

(a) RESIDENCE. No. 608 N. Patterson Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~ or ~~Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hucksters

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mollie Vogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Dietz Jr (Address) 508 Madeira St

15 Filed 16 1923

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14 1923

17

I HEREBY CERTIFY, That I attended deceased from 4-12 1923 to 4-14 1923

that I last saw him alive on 4-13 1923

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F Truitt Reynolds M. D.

19 (Address) 800 W Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Apr 17th 23
20 UNDERTAKER	ADDRESS
Wm C. Miller	2334 Jefferson St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74883 | HEALTH DEPARTMENT—CITY OF BALTIMORE | D74883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 S. St Dorsie Brooklyn Ward) 25

Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Reinhold Hoffman

(a) Residence No. 6 S. St Dorsie Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma Hoffman

6-DATE OF BIRTH (month, day and year) Oct. 4. 1857

7-AGE. 65 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Baker

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country)? Unknown

12-MAIDEN NAME OF MOTHER. Emma Lang

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-

(Informant) Adolph J. Hoffman

(Address) 1824 N. Charles Ave

Filed 1923 Robert P. Garrison, 19 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 16 23

17- I HEREBY CERTIFY, That I attended deceased from Feb 27, 19 22, to Jan 16, 19 23, that I last saw h— alive on Jan 14th, 19 23, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) mos. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. A. Brooke, M. D.

, 19 3 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	Jan 18, 1923
UNDERTAKER	ADDRESS
William Cook	502 E North Ave

Cook 3rd Potomac

IMPORTANT: Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. D. Leishear

(a) RESIDENCE NO. 29 Baltimore ST., WARD Spanows Point Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Sparrows Pt. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shift Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) 856

(c) Name of employer Spanows Point

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas B Leishear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Fannie Fillmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joseph E Henry

(Address) 1413 Edmondson Ave

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 12, 1923. to April 16. 1923.

that I last saw him alive on April 16, 1923.

and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kinzer, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 18 1923

20 UNDERTAKER William Cook Sons & Nuth

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's Information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE
TION is very important See instructions on back of certificates.

D74885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74885

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 919 Peach Al. St., 23 Ward) 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Sanders.(C).

(Residence in Baltimore: No. 919 Peach Al. St.; yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Single

6-DATE OF BIRTH, August 15, 1890. (Month) (Day) (Year)

7-AGE, 32 yrs. 8 mos. - ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Norfolk Va.

PARENTS.

10-NAME OF FATHER, John Sanders (C).

11-BIRTHPLACE OF FATHER, (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER, Susan -------.(C).

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Persell.(C)(cousin)

(Address) 101 W. West St.

15- APR 17 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1923. (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Bernhardt M. D. (Coroner)

Apr. 16, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	4/17 1923
20-UNDERTAKER, Samuel J. Nemsley	ADDRESS 578 N Bridge st

Be sure that every item is correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74886 HEALTH DEPARTMENT—CITY OF BALTIMORE D74886

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mary Tate

(a) RESIDENCE NO. 574 W. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5/2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bay View Hospital
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Sidney Tate

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary O'Neil

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mary Tate
(Address) 574 W Preston St

15 Filed APR 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1923 to April 13, 1923, that I last saw her alive on April 13, 1923, and that death occurred, on the date stated above, at 12 12 p. m.

The CAUSE OF DEATH* was as follows:

Melena Neonatorum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Congenital Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) J. A. McKay, M. D.

, 19 (Address) Bozman Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4/17 1923
20 UNDERTAKER	ADDRESS
Samuel S Hemsley	518 N Eddie

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74887 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-00 D74887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Cook.....

(a) Residence No. 220 N. Frederick St. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1862

7-AGE.	If LESS than 1 day.
60 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Charles Klein

11-BIRTHPLACE OF FATHER (city or town) (State or Country). German

12-MAIDEN NAME OF MOTHER. Catherine Long

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Municipal Hospital Records

(Address)

APR 17 1923

15- Filed P 192 ROBERT H. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from January 31, 19 23 to April 14, 19 23

that I last saw h.. alive on April 13, 19 23

and that death occurred, on the date stated above, at 8:05 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Infectious arthritis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McKay M. D.

4-14-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St Matthews Cem	April 17th 1923
20-UNDERTAKER.	**ADDRESS**
Leo G. Cook	North & Harford

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74888 D74888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Mosher St.: 14 WARD)

2-FULL NAME, James K. P. Diggs

(Residence in Baltimore: No. 713 Mosher St.: 8 yrs., mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 30, 1867. (Month) (Day) (Year)

7-AGE, 55 yrs. 4 mos. 14 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pastor Long A Church
(b) General nature of industry, business, or establishment in which employed (or employer): Trinity Baptist Ch

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John H Diggs

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary E. Clagett

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alberta M Diggs

(Address) 713 Mosher

15-

Filed APR 17 1923 191

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April 14, 1923 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Apr 18 1922, to April 14 1923, that I saw h in alive on April 14 1923, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

Cancer was removed + Gastro-enteros-tomy performed at Hosp Oct 3 1922 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. T. Coleman M. D.

Apr 15, 1923 (Address) 2032 McCulloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

17-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, April 18, 1923

20-UNDERTAKER Wm H Coale Son — ADDRESS 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 74889

D74889

D 74889

D74889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Doar

(a) RESIDENCE No. 1622 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or ~~divorced~~ HUSBAND (or) ~~WIFE~~ of Thomas N. Doar

6 DATE OF BIRTH (month, day, and year) Aug 1st 72

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Self~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Annes Co Md

PARENTS

10 NAME OF FATHER Sml Golden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Charlotte Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah A. Golden

(Address) 1105 Eastlands Ave

15 APR 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1923

17 I HEREBY CERTIFY, That I attended deceased from March 20. 1923. to April 14. 1923.

that I last saw her alive on April 14. 1923.

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Broncho Pneumonia + Bright Disease (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia + Bright Disease (duration) yrs. 7 mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. G. W. Kennard, M. D.

4-16 1923 (Address) 708 Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Apr 17 1923

20 UNDERTAKER Sam'l F. Case & Son

ADDRESS 400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

(Margaret Behm)

D74890 HEALTH DEPARTMENT—CITY OF BALTIMORE D74890

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE (No. Homewood Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Behm

(Residence in Baltimore: No. 2832 Guilford Av St.; yrs. 1/2 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: January 16 (Month) (Day) 1883 (Year)

7-AGE: 39 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: J. Frederick

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Katherine Reutz

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Behm

(Address) 2832 Guilford Av

15- Filed APR 17 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 13 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of Skull Cerebral Hemorrhage Result Accident

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) Edw. A. Norris M. D. (Coroner.)

April 16 1923 (Address) 2632 Roland Av

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, April 18 1923

20-UNDERTAKER, H. Sauter Sons ADDRESS 1710 Pract St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 lbs.

D74891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2207 Etting St., 14 Ward)

REGISTERED No. 16t001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Thos G. & Marie Warren

(a) RESIDENCE. No. 2207 Etting St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Baby Girl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 22 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Thos G Warren

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Marie Thomas

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Thos G Warren
(Address) 2207 Etting St

15 Filed ... 19 ...

Registrar

APR 17 1923 ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-1923

17 I HEREBY CERTIFY, That I attended deceased from 4-15-1923, to 4-15-1923, that I last saw him alive on 4-15-1923, and that death occurred, on the date stated above, at 8:30 p m.

The CAUSE OF DEATH* was as follows:

Died at birth

Premature

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm R. Boyle M. D.

19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	April 17 19
20 UNDERTAKER	ADDRESS
Thomas E Wright	1364 Mary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74892

CERTIFICATE OF DEATH.

129

D74892

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1124 Bolton ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie James

(Residence in Baltimore: No. 1124 Bolton St.: 5 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ..., 1[illegible]
(Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Cooking

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fredrick Barnes

(Address) 1124 Bolton St

15- ROBERT R. KRAUTER,

Filed APR 17 1923 191.... Burial Permit Clerk..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 14 1923, to April 15 1923, that I saw her alive on April 14 1923, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John C Stewart M. D.

4-17, 1923 (Address) 704 N Fayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 4-19, 1923

20-UNDERTAKER Frank Carter

ADDRESS 911 Pa ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

Bryson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74893

CERTIFICATE OF DEATH.

135 D74893

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Harlem ave, ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel M. Bryson

(a) RESIDENCE. NO. 1313 Harlem Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Clara Bryson

6 DATE OF BIRTH (month, day, and year) July 8 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	8	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) P. P. R. R. 673
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Wm. Bryson
11 BIRTHPLACE OF FATHER (city or town) (State or country) md
12 MAIDEN NAME OF MOTHER Eliza C. Thayer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mrs. Clara Bryson
(Address) 1313 Harlem Ave

15 Filed ....., 19....

APR 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1923, to April 15th, 1923, that I last saw him alive on April 14th, 1923, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Acute cystitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic prostatitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. R. Friedenwald, M. D.

4/16 1923 (Address) 614 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Cemetery	April 17 1923
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74894 — 100 D74894

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 515 N. Bekair Road ST., Rosedale (WARD)

2-FULL NAME Albert Russell Raske

(a) RESIDENCE No. 515 N. Bekair Road ST., Rosedale WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles H. Raske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Jennie Tull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greenwood Delaware

14 Informant Charles H. Raske (Address) 515 N. Belair Rd. Rosedale

15 APR 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1923, to April 16, 1923.

that I last saw him alive on April 16, 1923.

and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) ... yrs. ... mos. 7 ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert H. Chatten M.D.

April 19 23 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Cemetery

DATE OF BURIAL April 18 1923

20 UNDERTAKER Fredk Lassahn & Son

ADDRESS Fullerton

IMPORTANT: ALL ITEMS must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74895

CERTIFICATE OF DEATH.

90 D74895

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1410 Eutaw Place. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Clark

(Residence in Baltimore: No. 1410 Eutaw Place. St.; 69 yrs., 10 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	widower

6-DATE OF BIRTH, May 31, 1853
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
69 yrs. 10 mos. 15 ds.	....hrs. or.....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Thomas S. Clark

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Mary T. Bell

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard B. Clark

(Address) 1512 Eutaw Place

15- ROBERT R. KRAUTER,

Filed ....., 191... Burial Permit Clerk.....
Registrar.

APR 17 1923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.)... thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.)... find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Dis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

April 16, 1923 (Address) 28 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cemetery	Apr. 19, 1923
20-UNDERTAKER George J. Smith	ADDRESS 1532 Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Era Brown)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74896

D74896

CERTIFICATE OF DEATH.

101 001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Deland ST.: 22 WARD)

2-FULL NAME Erra Brown

(a) RESIDENCE. NO. 606 Deland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti Md

PARENTS

10 NAME OF FATHER Elizabeth Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balti Md

12 MAIDEN NAME OF MOTHER Frona Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Elizabeth Brown

(Address) 1626 Lexington St

15 Filed APR 17 1923

ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1923 to April 16, 1923.

that I last saw h[illegible] alive on April 16 1923.

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination Symptoms

(Signed) R R Flowers M. D.

(Address) 712 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	April 18 1923
20 UNDERTAKER	ADDRESS
L. L. Brown & Son	1618 Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74897

CERTIFICATE OF DEATH.

57 D74897

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Homestead ST., 9 WARD)

2-FULL NAME Grace G. Hasse

(a) RESIDENCE NO. 926 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Hasse

6 DATE OF BIRTH (month, day, and year) Sept 17 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	53	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Byron Crawford

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Cecile Brauer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Theo J. Hasse
(Address) 926 Homestead

15 APR 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17 I HEREBY CERTIFY, That I attended deceased from December 22, 1922, to April 15, 1923.

that I last saw her alive on April 14, 1923.

and that death occurred, on the date stated above, at 5.20 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? Clinical

(Signed) John S. Fenby, M. D.

4/16, 1923 (Address) 3520 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Apr 17 1923
20 UNDERTAKER John Ellerick	ADDRESS 2008 Eutaw

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

162 942
D74898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 - 001
100 D74898

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST., 17 WARD)

2-FULL NAME James L. Culver.

(a) RESIDENCE No. 3309 Guilford Ave. ST., City WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ James B. Culver (father).

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1922.

7 AGE: Years ~~—~~ Months 6 Days 11 If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry, business, or establishment in which employed (or employer): (")
(c) Name of employer: (")

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: James B. Culver.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Mae Fiscney.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed APR 17 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1923, to April 17, 1923, that I last saw him alive on April 17, 1923, and that death occurred, on the date stated above, at 6 00 A m.

The CAUSE OF DEATH* was as follows:

Eczema & secondary skin infection

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A A Weed, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Apr 19 1923

20 UNDERTAKER: John Ellicott

ADDRESS 2008 Aisquith

INSTRUCTIONS should be carefully supplied. AGE should be stated EXACTLY. Every item of information may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74899

CERTIFICATE OF DEATH.

15 74-001 D74899

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Lakeland ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B Deal

(a) RESIDENCE. No. 1734 Lakeland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Kraut Deal

6 DATE OF BIRTH (month, day, and year) Nov 20, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Deal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Adaline Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va.

14 Informant Ethel Margin (Address) 1734 Lakeland

15 FILED APR 17 1923 ROBERT R. KRAUTER, Assistant Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 16, 1923, that I last saw him alive on April 16, 1923, and that death occurred, on the date stated above, at 3.25 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred C Jewett, M. D.

, 19 (Address) 2576 Penn. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 20 1923
20 UNDERTAKER John Ullrich	ADDRESS 200 E Oliver

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D74900

D74900
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Baxter

(a) RESIDENCE NO. 1909 N. Payson St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Baxter

6 DATE OF BIRTH (month, day, and year) 1862 Aug 20.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital.
(Address)

15 Filed ..... 19 .....
APR 17 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 19 23

17 I HEREBY CERTIFY, That I attended deceased from September 1, 19 22, to April 16, 19 23.

that I last saw h.im alive on April 15, 19 23,

and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. McCa, M. D.

4-16-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Mays Hampden	Apr 18 23 19
20 UNDERTAKER	ADDRESS
H S Marshall	3539 Fall Rd

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74901

CERTIFICATE OF DEATH.

D74901

75-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Burnett

(a) RESIDENCE No. 3813 Roland Ave Ward 8th Hospital

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE: Years 72 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lumber Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber - 86

(c) Name of employer: Not been employed Recently -

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John M. Burnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant: B.V.H. Records -

(Address)

15 Filed APR 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1923, to Apr 16, 1923, that I last saw him alive on Apr-16, 1923 and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Paraplegia -

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Hospital

Did an operation precede death? No Date of no

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. M. Shipley, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet DATE OF BURIAL Apr 19 23

20 UNDERTAKER: A S Marshall ADDRESS 3539 Fallsd

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See Instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74902 ✓ 45 D74902

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N. Monroe St. ST., 20 WARD)

2-FULL NAME Harry F. McCullough

(a) RESIDENCE NO. 521 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie McCullough

6 DATE OF BIRTH (month, day, and year) Sept 23, 1869

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
53	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Unemployed 066

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles F. McCullough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Sarah M. Kline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Ella M. McCullough (Address) 521 N. Monroe St.

15 Filed APR 17 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1923, to April 15, 1923, that I last saw him alive on April 15, 1923, and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cachexia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F Lemmon, M. D.

4/16, 1923 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 18 1923

20 UNDERTAKER John B Spence ADDRESS 1325 N Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74903

CERTIFICATE OF DEATH.

D74903

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 617 N Bantalm ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Jones

(a) RESIDENCE. NO. 617 N Bantalm ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Lida A Jones

6 DATE OF BIRTH (month, day, and year) Sept 23 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lately Employed

(b) General nature of industry, business, or establishment in which employed (or employer) Clerical

(c) Name of employer Batts Lerby 809

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John A Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Lida A Jones
(Address) 617 N Bantalm

15 Filed APR 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to April 16, 1923, that I last saw him alive on April 15, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Insanition

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Oesophagus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) Edwin B Lennard, M. D.

By 4/16, 1923 (Address) 718 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	April 18 1923
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002 D74904

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 N. Port ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E. Bohle

(a) RESIDENCE No. 233 N. Port ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 1918

7 AGE: Years 5 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John S. Bohle

11 BIRTHPLACE OF FATHER (city or town) (State or country): York P.A.

12 MAIDEN NAME OF MOTHER: Mary Wilhelmi

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: John S. Bohle

(Address) 233 N. Port St

15 APR 17 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 16, 1923, that I last saw her alive on April 16, 1923, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Hypostatic Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Convulsions - Epileptic Fit

(duration) yrs. mos over ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Grey, M. D.

, 19 (Address) 571 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: April 19 1923

20 UNDERTAKER: Jos. J. Kerr

ADDRESS: 156 N. Luzerne Ave.

CAUSE OF DEATH should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Date of burial extended to 4/18/23. Gotfredrick & Trumpet Auto Cons

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74905

CERTIFICATE OF DEATH

D74905 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lott Wiley Jr.

(a) RESIDENCE NO. 731-N-Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 Years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Harrowsmith Mfg Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Leesburg Va

PARENTS

10 NAME OF FATHER Lott Wiley Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lillie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lott Wiley Sr (Address) 821-23 St Wm Harbert Co

15 APR 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12- 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-6, 1923, to 4-12-, 1923, that I last saw him alive on 4-12-, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4-13, 1923 (Address) 611-N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leesburg Va

DATE OF BURIAL 4/19 1923

20 UNDERTAKER Samuel F. Hensley & Wm Riddle

ADDRESS 578

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74906

CERTIFICATE OF DEATH.

164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Homewood Ave. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Gibson

(a) RESIDENCE No. 1023 Homewood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Gibson

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 75 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of Industry, business, or establishment in which employed (or employer): Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Calooley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Andrew Gibson (Address) 1023 Homewood Ave

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/15 1922 to 4-14 1923, that I last saw h alive on 4-13 1923, and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Senility

Contusion (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of Lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Wise, M. D.

(Address) 914 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: April 18 1923

20 UNDERTAKER: H.C. Windefeld — ADDRESS: 914 Gramont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74907

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH 1626 Hollins St.,

CITY OF BALTIMORE: (No. 1626 Hollins St., ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rohr

(a) RESIDENCE NO. 1626 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.,

PARENTS

10 NAME OF FATHER Randolph Rohr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.,

12 MAIDEN NAME OF MOTHER Mary [illegible] Hauser

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.,

14 Informant Randolph Rohr
(Address) 1626 Hollins St.,

15 Filed 4/17 1923 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 16, 1923, to Apr 17, 1923,

that I last saw h[illegible] alive on Apr 16, 1923,

and that death occurred, on the date stated above, at 3 41 m.

The CAUSE OF DEATH* was as follows:

Asthenia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) F. Wirnt M. D.

4/17, 1923 (Address) 1302 N Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt, Olivet Cemetery

DATE OF BURIAL April 17, 23

20 UNDERTAKER Harry Witzke

ADDRESS 1531 W Lombard S

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74908

D74908

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 ST., WARD) Municipal Tuberculosis Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Dixon

(a) RESIDENCE NO. 1515 Fayette st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Chester South Carolina

PARENTS

10 NAME OF FATHER John Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Norah Wilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) M.T.H.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1923

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1923, to April 14, 1923, that I last saw him alive on April 14, 1923, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Fecal Fistula

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Ferruccio L. Dadoglianes, M. D.

4-14-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS APR 17 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74909

CERTIFICATE OF DEATH.

100-001

D74909

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas W. Sermon

(a) RESIDENCE No. 411 N. Milton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
66	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of Industry, business, or establishment in which employed (or employer) 011

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 APR 17 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 19 23

17

I HEREBY CERTIFY, That I attended deceased from December 19 19 19, to April 13. 19 23.

that I last saw him alive on April 13, 19 23,

and that death occurred, on the date stated above, at 4:40 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

4-14-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health, ADDRESS APR 17 1923

Dr. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pharyngeal

Spec.—1-10-21—M&T—1500 Blks.

D74910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74910

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Ridgely ST. 21 WARD)

2-FULL NAME Annie Mary Lacher

(a) RESIDENCE NO. 806 Ridgely ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Wedow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Lacher

6 DATE OF BIRTH (month, day, and year) Dec. 8 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frabb. Ind

PARENTS

10 NAME OF FATHER John Schulz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Lacher

(Address) 806 Ridgely

17 1923 Robert P. Harrison

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1923, to Apr. 15, 1923, that I last saw her alive on Apr. 15, 1923, and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Appoplexy.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NO Date of —

Was there an autopsy? - NO -

What test confirmed diagnosis? Clinical

(Signed) W. H. Spillinger M. D.

(Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 18 1923
20 UNDERTAKER	ADDRESS
James Dinan & Son	1005 S Pacast

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74911 1934

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74911

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linnus Winfrey

(a) RESIDENCE NO. 1304 38, 1702 E ST., WARD Wellville, Va,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred some months. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie Winfrey

6 DATE OF BIRTH (month, day, and year) July 11 - 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Ned Winfrey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Millie Street

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 JOHNS HOPKINS HOSPITAL
Informant
(Address) Records

15 Robert P. Harrison, M. D.
Registrar

APR 17 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1923, to April 14, 1923, that I last saw him alive on April 14, 1923 and that death occurred, on the date stated above, at 6 20 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Septicaemia pneumococcus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture.

(Signed) E. Cowles Andrus, M. D.

. 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilson Funeral Co. Balto	April 17, 23
20 UNDERTAKER John F. Denny (via B. & O.)	ADDRESS 715 Light St

INSTRUCTIONS

This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74912

CERTIFICATE OF DEATH. 1/4-001 D74912

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Cumberland St., 15 WARD)

2-FULL NAME Thomas Monroe Johnson

(a) RESIDENCE No. 712 Cumberland ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary J. Johnson

6 DATE OF BIRTH (month, day, and year) Mar. 25 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	68	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) at Forge Yard

(c) Name of employer Kunz & Hagerty

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Thos M. Johnson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Lucas

13 BIRTHPLACE OF MOTHER (city or town) Wake Mat
(State or country) Md

14 Informant Mr Thos. M. Johnson 3rd
(Address) 711 S. 16th Boston Mass.

15 Filed ....., 19.....
Registrar

Robert F. Garrison,
Burial Permit Clerk.

17 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 16th 1920 to Apr 16 1923,
that I last saw him alive on Apr. 16th 1923,
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Hem. of brain)
Hemiplegia

18 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Failing heart
(duration) yrs. mos. 12 hrs ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Visible

(Signed) C. A. Smith, M.D.

4/16, 1923 (Address) 1605 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Apr. 19 1923
20 UNDERTAKER Wm Pickus Sons	ADDRESS Pratt

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74913

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 Cumberland ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Clara Logue

(a) RESIDENCE NO. 735 Cumberland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wh	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond Logue

6 DATE OF BIRTH (month, day, and year) July 29th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Briggs

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Maggie Lochner

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Thomas Briggs (Address) 735 Cumberland St.

15 Filed 1923 19 Robert P. Harrison, Registrar

Burial Permit Cert.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17th 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1922, to Apr. 17th, 1923.

that I last saw h[illegible] alive on Apr. 16, 1923,

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) Not Known yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis No Data for 4 days (duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) [illegible] M. D.

4/17, 1923 (Address) 1605 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: April 19 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 562 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74914

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH Women's Hospital

REGISTERED NO.

CITY OF BALTIMORE: (NO. Lafayette ave & Johns St. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME mrs Margaret Reeder Cordner

(a) RESIDENCE NO 1205 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William Cordner

6 DATE OF BIRTH (month, day, and year) Jan 28, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millinery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Leonardtown
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm George Reeder

11 BIRTHPLACE OF FATHER (city or town) Leonardtown
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine McPherson

13 BIRTHPLACE OF MOTHER (city or town) Warrington
(State or country) Virginia

14 Informant Thomas A. Reeder
(Address) 612 E 33rd Sparrows Point

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-11, 1923, to 4-17, 1923.

that I last saw her alive on 4-17, 1923,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Toxic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-12-23

Was there an autopsy? No 4-17-23

What test confirmed diagnosis? Clinical findings

(Signed) J E Plyler M. D.

19 (Address) Womans Hospital Lafayette ave & Johns St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mechanicsville Md

DATE OF BURIAL April 18 1923

20 UNDERTAKER Ehrmann Cook

ADDRESS 502 E Pratt

CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should state it in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74915 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74915

CERTIFICATE OF DEATH. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Fremont Ave ST., 17 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Riley

(a) RESIDENCE NO. 2004 Fremont Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Abigail Riley.

6 DATE OF BIRTH (month, day, and year) 1851 Nov. 11

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Meter work
(b) General nature of industry, business, or establishment in which employed (or employer) Md Meter Mfg. 86
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Rice.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Grace B Rusk,
(Address) 2004 Fremont ave.

15 1/19/23 Robert P. Harrison, 19
Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl 8, 1923, to Apl 15, 1923, that I last saw h[illegible] alive on Apl 15, 1923, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis (?).

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 424 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 18 1923
20 UNDERTAKER	ADDRESS
Geo. L. Rusk	1735 Hanford Ave.

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important.

D74916 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D74916

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 844 Orland St., 21 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... melvin jackson

(Residence in Baltimore: No. 844 Orland St' St.; 1 yrs., 1 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	single

6-DATE OF BIRTH. March (Month) (Day) 1922 (Year)

7-AGE. 1 yrs. 1 mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER. Chas Jackson

11-BIRTHPLACE OF FATHER, (State or Country). md

12-MAIDEN NAME OF MOTHER. Lenna Busch

13-BIRTHPLACE OF MOTHER, (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Chas Jackson

(Address) 844 Orland St

15- Robert P. Harrison, 192.....

APR 17 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 17 (Day), 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. W. Fenton M. D. (Coroner.)

April 17 1923 (Address) 709 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Magothy. md	Apr 18 1923
20-UNDERTAKER. John H. Soads	ADDRESS 1442 Eutaw St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Tankard) ✓

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74917 — CERTIFICATE OF DEATH. — 129 — D74917

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Patchen ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Tankard

(a) RESIDENCE. NO. 602 Patchen ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Tankard

6 DATE OF BIRTH (month, day, and year) — 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ruben Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Matilda — 4/12

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) B. Tankard 602 Patchen St.

15 17 1923 Robert P. Harrison, Registrar

Deputy Health Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/9, 1922, to 4/16, 1923, that I last saw him alive on 4/15, 1923, and that death occurred, on the date stated above, at 2 24 A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency &
Chr. Nephritis

(duration) yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. M. Battle, M. D.

(Address) 2139 D.T. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	4-19 1923
20 UNDERTAKER John H. Tradum	ADDRESS 1142 Hastings St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74918

CERTIFICATE OF DEATH.

9 D74918

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3919 Falls Road ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Elnora Baker

(a) RESIDENCE NO. 3919 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 8-1922

7 AGE: Years — Months 8 Days 9 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Chas. E. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Maggie L. Kerr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Chas. E. Baker

(Address): 3919 Falls Road

15 17 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1923, to April 17, 1923, that I last saw her alive on April 17, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) A. E. Daner, M. D.

4 17 1923 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: April 18 1923

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Falls Rd.

HEALTH RECORDS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74919

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1319 N. Carey ST.: 15 WARD)

2-FULL NAME Sarah Davis

(a) RESIDENCE. No. 1319 N Carey ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Col-	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Davis

6 DATE OF BIRTH (month, day, and year) April 16th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home work.

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Charles Creek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland -

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Josephine Davis Daughter
(Address) 1319 N. Carey st

15 APR 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14th, 1923, to April 16th, 1923, that I last saw her alive on April 16-, 1923, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) about 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Disease

(duration) about yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 19 1923

20 UNDERTAKER George T. A. Gibson ADDRESS 513 Gaurner

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. Every item of information is a PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74920

CERTIFICATE OF DEATH.

46 D74920

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Baker St ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Page

(a) RESIDENCE NO. 508 Baker St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Pa

PARENTS

10 NAME OF FATHER Steven Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Virgie P. Leighman
(Address) 508 Baker St

15 APR 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3 - 1922 to April 15 1923.

that I last saw her alive on April 15 - 1923.

and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy & Carcinoma of Uterus

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus (duration) 1 yrs. 4 mos. 17 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Dr. J. W. Kennard, M. D.

4-16 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL April 23

20 UNDERTAKER George H Holland

ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74921

CERTIFICATE OF DEATH.

31 D74921

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 N. Carey ST. 16 WARD)

2-FULL NAME Ella Ball

(a) RESIDENCE NO. 819 N Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A Ball

6 DATE OF BIRTH (month, day, and year) Unknown 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Archie Ritchie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Octavia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Jas A Ball

(Address) 819 N. Carey

15 Filed APR 18 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15 1923

17 I HEREBY CERTIFY, That I attended deceased from March 31st, 1923, to April 15th, 1923, that I last saw her alive on April 15th, 1923, and that death occurred, on the date stated above, at 2.10 P.M.

The CAUSE OF DEATH* was as follows: Acute Phthisis Pulmonal

(duration) Abt 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. Abt ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) Elbridge M. D.

, 19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL 4 18 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS 1412 Ashland Av

CAUSE OF DEATH should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74922

CERTIFICATE OF DEATH.

90 D74922

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marlborough Ave ST., 14 WARD)

2-FULL NAME Samuel Heineman

(a) RESIDENCE NO. Marlborough Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Heineman

6 DATE OF BIRTH (month, day, and year): Oct 29th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cigar Mfg.
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Jacob Heineman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs S Heineman
(Address): Marlborough Ave

15 APR 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1922, to April 16, 1923, that I last saw h[illegible] alive on April 16, 1923, and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris: myocarditis:

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

April 17, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alvah Sheldon	April 18th 1923

20 UNDERTAKER	ADDRESS
David Sondheim	1818 W Balto St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be given. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74923

CERTIFICATE OF DEATH.

74-001 D74923

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1922 Eutaw Place St. 44 WARD)

2-FULL NAME Jacob Hochschild

(a) RESIDENCE NO. 1922 Eutaw Place St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3½ yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minna Hochschild

6 DATE OF BIRTH (month, day, and year) July 14 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mr. Louis Bushey

(Address) 1922 Eutaw Place

15 APR 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/1923.

17 I HEREBY CERTIFY, That I attended deceased from January 29, 1923, to April 17, 1923,

that I last saw him alive on April 17, 1923,

and that death occurred, on the date stated above, at 1 40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteria-sclerosis

cerebral haemorrhage

(duration) ..... yrs. 2 mos 19 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles I. Pressman M. D.

, 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	4/19/1923
20 UNDERTAKER	ADDRESS
David Sondheim	115 200 Mt. Royal Ave

INFORMANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D74924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Ensor st .. ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Jacob Abramson

(a) RESIDENCE NO. 637 Ensor St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Bracha Abramson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Abramson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Isaacs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E. Preston St

15 APR 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to April 17, 1923, that I last saw h[illegible] alive on April 17, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mc J Bergin, M. D.

4/17, 1923 (Address) 210 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Rosedale	April 18 1923

20 UNDERTAKER Jacob Lewis ADDRESS 1439 E. Preston

CAUSE SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 D74925

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 St. Broadway ST., 6 WARD)

2-FULL NAME Esther Goldstein

(a) RESIDENCE NO. 208 St Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Goldstein

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Baltimore St

15 Filed APR 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1923, to April 17, 1923, that I last saw her alive on April 17, 1923, and that death occurred, on the date stated above, at 7 25 9m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

1

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Coma —

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Frank C Bressler, M. D.

, 19 (Address) 125 St Paul —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Andrew Wash. Road — DATE OF BURIAL April 18 1923

20 UNDERTAKER Jack Lewis, 1439 E Balto — ADDRESS

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74926

CERTIFICATE OF DEATH.

74-001 D74926

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1028 N. Fulton Ave. St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob F. Gerwig

(Residence in Baltimore: No. 1028 N. Fulton Ave. St.; yrs. 66 mos. ds.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	widower

6-DATE OF BIRTH, Dec. 24, 1856
(Month) (Day) (Year)

7-AGE, 66 yrs. 3 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: architect
(b) General nature of industry, business, or establishment in which employed (or employer): D

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Chas. Gerwig

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Pfeiler

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. F. Gerwig

(Address) Wash. D. C.

15-

APR 18 1923 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ....yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) no known

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. T. Hemmeter M. D.
(Coroner.)

April 16, 1923 (Address) 130 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem.	Apl. 18, 1923

20-UNDERTAKER	ADDRESS
Wm. Chas. A. Leide	Arlington Ave

Spec.—1-10-21—M&T—1500 Bks.

Liddell

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D74927

D74927

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Brune St ST., 17 WARD)

2-FULL NAME John Warren Riddell

(a) RESIDENCE NO. 717 Brune St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 27, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Glenn A Riddell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Myrtle Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Scrivner

(Address) 717 Brune St

15 Filed APR 18 1923 ROBERT R. KRAUTER, Bucial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1923 to April 17, 1923.

that I last saw him alive on April 17, 1923

and that death occurred, on the date stated above, at 11 00 m.

The CAUSE OF DEATH* was as follows:

Septicemia (Cause)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Culture examined

What test confirmed diagnosis?

(Signed) Dr. Felty M. D.

(Address) 2724 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Apr 1923
20 UNDERTAKER Wm J Rickmers Sons	ADDRESS North Pa

IMPORTANT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D74928

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. St Agnes Hospital ST., 70 WARD)

2-FULL NAME George F Baker

(a) RESIDENCE No. 115 N. Bentalou ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Katie Baker

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-binder

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

864

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER George F. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mary 2

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Katie Baker

(Address) 115 No Bentalou

15 Filed APR 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1923, to April 15, 1923, that I last saw h[illegible] alive on April 15, 1923, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial failure following prostatectomy for Carcinoma (duration) 3 days ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-14-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Karl J Steinmueller, M. D.

4/18, 1923 (Address) 327 N. Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr. 18" 1923

20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Bolton St

CAUSE OF DEATH is very important. See instructions on back of certificates. TION should be carefully supplied. AGE should be stated EXACTLY. Every item of information may be properly classified. PHYSICIANS should state Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74929

CERTIFICATE OF DEATH. 15 129

D74929
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2533 Shirley Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Cadwallader

(a) RESIDENCE NO. 2533 Shirley Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt. Lewis W. Cadwallader

6 DATE OF BIRTH (month, day, and year) May 12" 1838

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James J. Chalmers

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann Wilhelm

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Capt. Lewis W. Cadwallader (Address) 2533 Shirley Ave.

15 FILED APR 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17" 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 17, 1923, that I last saw h[illegible] alive on April 16, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis/
Arterio-sclerosis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Uraemia —

(Signed) Thelma F. Guillman, M. D.

4/17 1923 (Address) 6 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Apr 19" 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St

IMPORTANT—RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74930

CERTIFICATE OF DEATH.

90 D74930
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 Stinson St. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman C. Vogell

(a) RESIDENCE NO. 302 Stinson St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah I. Vogell

6 DATE OF BIRTH (month, day, and year) Mch. 23" 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	74	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Feorge Vogell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Daisy Eichner
(Address) 302 Stinson St.

15 Filed APR 18 1923 ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16" 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1923. to April 16, 1923.
that I last saw h[illegible] alive on April 16, 1923.
and that death occurred, on the date stated above, at 12.50 Noon

The CAUSE OF DEATH* was as follows:

Mytral regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no Physical

What test confirmed diagnosis?

(Signed) Asa L Wessels, M. D.

4/16 1923 (Address) 2565 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Apr 19 1923

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74931

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 2012 Bank St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Hovs

(a) Residence No. 2012 Bank St., 2nd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Marr

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 23rd 1852

7-AGE, 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mr Louis Thal

(Address) 27 E Hoover St

15- Filed APR 18 1923 By ROBERT H. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 17-1923

17- I HEREBY CERTIFY, That I attended deceased from Apr 9, 1923, to Apr 17, 1923, that I last saw h.im alive on Apr 16, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? >

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A L Linthicum, M. D.

4/17, 1923 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, 1st Hebrew Cem — DATE OF BURIAL, April 19 1923

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2060 Eastern Ave

IN PRINT TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74-001 D74932

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Tudor Hall, University Parkway ST., 12 WARD)

2-FULL NAME Mary Howard Lloyd
Wye House, Talbot Co. Md

(a) RESIDENCE NO.... ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Edward Lloyd

6 DATE OF BIRTH (month, day, and year) June 12th 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	91	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Howard

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Phoebe Key

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country) Maryland

14 Informant E. Howard Lloyd
(Address) Baltimore Md

15 Filed APR 18 1923 ROBERT R. KRAUTER, Registrar
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20 1923, to April 16th 1923.

that I last saw her alive on April 16th 1923,

and that death occurred, on the date stated above, at 5.25 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos 25 ds.

CONTRIBUTORY (Secondary) Hypertension, Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Hypertension

(Signed) Jos. Chatard, M. D.

April 18th 1923 (Address) 48 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wye House Cem Talbot Co Md	April 19th 1923
20 UNDERTAKER Henry H. Jenkins Sons Co	ADDRESS McCulloh & Orchard Sts

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74933

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 672 Pine Al. ST., 4 WARD)

2-FULL NAME Louisa Paine

(a) RESIDENCE NO. 672 Pine Al. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas A. Payne.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jos. Payne

(Address) 521 N. Fountain St

15 FILED APR 18 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch, 1923, to Apl 16, 1923, that I last saw h alive on Apl 16, 1923 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Organic Dis Heart

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmy Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Apl 17 1923 (Address) 737 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Apl. 20 1923
20 UNDERTAKER James H. Lewis	ADDRESS 313 Park Ave H.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D74934 HEALTH DEPARTMENT--CITY OF BALTIMORE D74934

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C 7

CITY OF BALTIMORE (No 2316 Hunter St St. 12 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ruth Tyler

(Residence in Baltimore: No. 2316 Hunter St St.; yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE C

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Oct 7, 1921 (Month) (Day) (Year)

7 AGE 1 yrs. 6 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Louisville Ky

PARENTS

10 NAME OF FATHER Robt Tyler

11 BIRTHPLACE OF FATHER (State or country) Gallatin Pa

12 MAIDEN NAME OF MOTHER Annie Tyler

13 BIRTHPLACE OF MOTHER (State or country) Portsmouth Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt Tyler

(Address) 2316 Hunter

15 Filed APR 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 18, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16th, 1923, to, April 16, 1923, that I saw h[illegible] alive on April 16, 1923, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Measles.

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY) Bronchitis

(Duration) yrs. mos. 3 ds.

(Signed), C. T. Getrost M. D.

April 18, 1923 (Address) 2413 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Laurel Cem

DATE OF BURIAL April 19, 1923

20 UNDERTAKER [illegible] & Sons

ADDRESS 1725 [illegible] Oakland

Spec.—8-24-1d—M. & T.—2000 Blks.

D74935 HEALTH DEPARTMENT—CITY OF BALTIMORE D74935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Pitcher ST.; 14 WARD) REGISTERED No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Ann Dyer

(Residence in Baltimore: No. 611 Pitcher St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ..., 1873
(Month) (Day) (Year)

7-AGE, 71	If LESS than 1 day,
....yrs....mos....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): House Keeper

9-BIRTHPLACE, (State or Country), Talon Shore Md

PARENTS.

10-NAME OF FATHER, Henry Small

11-BIRTHPLACE OF FATHER (State or Country), Talon Shore Md

12-MAIDEN NAME OF MOTHER Elizabeth Stanly

13-BIRTHPLACE OF MOTHER (State or Country), Talon Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Short

(Address) 611 Pitcher St

15-

APR 18 1923 19..., ROBERT N. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 20 1923, to Apr 16 1923, that I saw h[illegible] alive on Apr 16 1923, and that death occurred, on the date stated above, at 8 05 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Apr 17, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	April 19, 1923.
20-UNDERTAKER [illegible]	ADDRESS 1725 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74936 **CERTIFICATE OF DEATH.** 129 D74936

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1426 Linden Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Martha Kingsland

(a) Residence No. 1426 Linden Ave St., 14 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? 85 yrs. 4 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Marshall M Kingsland

6-DATE OF BIRTH (month, day and year) Dec-8-1842

7-AGE. 80 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer). none

(c) Name of employer. none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Nicholas Poppleim

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Frankfort Germany

12-MAIDEN NAME OF MOTHER. Susanna Thomsen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Maryland

14-Informant Mrs Laura L Ricketts Sister

(Address) 1605 Eutaw Place

15-Filed APR 18 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-15-23

17- I HEREBY CERTIFY, That I attended deceased from 4-11- 1923, to 4-15 1923

that I last saw her alive on 4-15- 1923

and that death occurred, on the date stated above, at 1030 P. M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis - General

Chronic nephritis

Acute Bronchitis -

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Uremia -

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. DeMarco M. D

, 19 (Address) 1640 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery — DATE OF BURIAL. Apr 17 1923

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Harry S. Dungan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74937

CERTIFICATE OF DEATH.

101-001 D74937

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 722 Eaton ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry S. Dungan

(a) RESIDENCE NO. 722 Eaton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24, 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER S Henry Dungan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) City

12 MAIDEN NAME OF MOTHER Annie Brown.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mr. W. Dungan
(Address) 722 Eaton ave.

15 Filed APR 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 16, 1923.

that I last saw him alive on April 16, 1923.

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Was blood specimen sent to Wassermann Laboratory?

What test confirmed diagnosis?

(Signed) H M Stevenson, M. D.

4/17, 1923 (Address) 2733 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	4/18 1923
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son - 1938	Lafayette ave.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D74938

1-PLACE OF DEATH St Vincents Infant Asy.

CITY OF BALTIMORE: (No. 1401 division ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frankie Tamolionis

(a) RESIDENCE No. 1294 James Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1921 Noknow

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Volter Tamilonis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Marta [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Volter Tamulonis

(Address) 1204 James Street

15 Filed APR 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1923, to April 16, 1923, that I last saw him alive on April 16, 1923 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goodstorough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April. 18. 1923
20 UNDERTAKER	**ADDRESS**
John Grebliauckas	425 S Paca St

MANY BLANKS must be carefully supplied. AGE should be stated EXACTLY. Every item of information should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Hart

D74939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-00 D74939

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2446 Fleet St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John R. Hart

(Residence in Baltimore: No. 2446 Fleet St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Apr 14th 1923 (Month) (Day) (Year)

7-AGE. ... yrs. ... mos. 3 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Ch
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Raymond Hart

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Lillian Wolfar

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Hart

(Address) 2446 Fleet St

15-

Filed APR 18 1923 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr 17th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Norton M. D.
Coroner

1923 (Address) Garden Bay

*(State the Disease Causing Death, or, if Accidental from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary

DATE OF BURIAL. Apr 18 1923

UNDERTAKER, Wm Fialkowski

ADDRESS 1618 East

*state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should

Spec. 1-10-21—M&T 1500 Blks.

(Virgie M. Booker)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74940

CERTIFICATE OF DEATH.

31

D74940

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2541 Lanvale ST., 7th WARD)

2-FULL NAME Virgie M. Booker

(a) RESIDENCE NO. 2541 Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Booker

6 DATE OF BIRTH (month, day, and year) Jan 3 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	20	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Stout

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Jennie Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) John Stout 831 Union Ave

15 (Filed) APR 18 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1923.

17

I HEREBY CERTIFY, That I attended deceased from Apr 15, 1923, to Apr 16, 1923.

that I last saw her alive on Apr 16, 1923.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Vaud Ville

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) John A. Krauter M. D.

19 (Address) 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden

DATE OF BURIAL: Apl 19, 1923

20 UNDERTAKER: Cohenouth & Son

ADDRESS: Chestnut Ave

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D74941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74941

CERTIFICATE OF DEATH.

94

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 909 N. Appleton ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Wakely Harvey

(a) RESIDENCE NO. 909 N. Appleton ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alexander Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Knoxville Tenn

12 MAIDEN NAME OF MOTHER Amelia Finch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Abergavenny Wales

14 Informant Alexander Harvey
(Address) 909 Appleton St

15 APR 18 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15th, 1923, to April 18th, 1923, that I last saw him alive on April 17th, 1923, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. H. H. Cliff, M. D.

4/18, 1923 (Address) 1312 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Apl 18-1923
20 UNDERTAKER	ADDRESS
Putnam & Post	1230 W. Lafayette

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Speed.

D74942 HEALTH DEPARTMENT—CITY OF BALTIMORE D74942

51

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1642 St. Joseph ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elezabeth Speed

(a) RESIDENCE No. 1642 St. Joseph ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meredith Speed.

6 DATE OF BIRTH (month, day, and year) May 10 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) O'D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wakeco. N. C.

PARENTS

10 NAME OF FATHER Harry Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Annie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) Fanny Benson 1642 St. Joseph.

15 APR 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-1923

17 I HEREBY CERTIFY, That I attended deceased from 3-29-1923, to 4-17-1923, that I last saw h- alive on 4-16-1923, and that death occurred, on the date stated above, at 6-A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Rheumatic fever

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W H Cargill, M. D.

4-18-1923 (Address) 611-N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marina N. C.	April 18 1923
20 UNDERTAKER	ADDRESS
Mrs J. G. Locks.	302 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74943

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Walbrook Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Schriber

(a) RESIDENCE No. 2011 Walbrook Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Schriber.

6 DATE OF BIRTH (month, day, and year) Unknown 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

137

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Bertha Burlow

(Address) 2011 Walbrook Ave

15 APR 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to April 16th, 1923,

that I last saw her alive on April 16, 1923,

and that death occurred, on the date stated above, at 4.50 P.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis (Interstitial)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination & examination of urine

(Signed) G W Bellis, M. D.

, 19 (Address) 2224 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Mt Olive Cem. Md	Apr 19 1923

20 UNDERTAKER Jos. A. Lorman & Son

ADDRESS 901 Hollins St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec.—8-24-14—M. & T.—2000 Blks.

D74944

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D74944

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 Canal ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William R. Williams

(Residence in Baltimore: No. 312 Canal St.; 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, April (Month) 15 (Day) 1906 (Year)

7-AGE, 17 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Dale Md

PARENTS.

10-NAME OF FATHER, John Williams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Carrie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Williams

(Address) 317 Canal St

15- APR 18 1923

Filed ....., 191... ROBERT R. KRAUTER,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 15 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 14 1923, to Apr 15 1923, that I saw h[illegible] alive on Apr 15 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None known

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. J. Kelly M. D.

Apr 16, 1923 (Address) 132 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Apr 18, 1923

20-UNDERTAKER Samuel Knowles ADDRESS 718 Dale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74945

CERTIFICATE OF DEATH.

100-001 D74945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2836 Frederick Ave., 20 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Warfield,

(a) RESIDENCE NO. 2836 Frederick Ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 15, 1923.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. H. Warfield.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Thomas.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mary E. Warfield.
(Address) 2836 Frederick Ave

15 Filed ....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18. 1923.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15. 1923. to Apr. 18. 1923. that I last saw him alive on Apr. 18. 1923. and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia.
(Primary.)
(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs.

(Signed) J. Thos. Horton, M. D.

4/18 1923 (Address) 885 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet — DATE OF BURIAL April 19 1923

20 UNDERTAKER John J. Fields — ADDRESS 1200 W Lombard St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D74946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D74946 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 611 Spring Dale Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Silas McClanahan

(a) Residence No. 611 Spring Dale Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma McClanahan

6-DATE OF BIRTH (month, day and year) July 4 1847.

7-AGE. 75 yrs. 9 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer Retired

9-BIRTHPLACE (city or town) (State or Country). King George Co. Va.

PARENTS.

10-NAME OF FATHER. Wm. E. McClanahan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). King George Co. Va.

12-MAIDEN NAME OF MOTHER. Mary Hite.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). King George Co. Va.

14- (Informant) W. E. McClanahan (Address) 3508 Bank St.

15- Filed APR 18 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 17, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 15 1922 to April 17 1923

that I last saw h[illegible] alive on April 14 1923

and that death occurred, on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver —

Diabetes —

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Thorough Examination

(Signed) W. E. McClanahan, M. D.

(Address) 3508 Bank St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	April 19, 1923
20-UNDERTAKER.	ADDRESS
George J. Smith	153 Hollins St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

163023. D74947

HEALTH DEPARTMENT—CITY OF BALTIMORE D74947

CERTIFICATE OF DEATH. X131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. McAbee.

(a) RESIDENCE NO. Sharptown, Md ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced — ~~HUSBAND~~ (or) WIFE of Martha E. McAbee.

6 DATE OF BIRTH (month, day, and year) June 7, 1864.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
58.	10.	11.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: do

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER Thomas A. McAbee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Mary Wilkinson,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Robert E. Harrison,

15 Filed APR 18 1923 19 ... Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923. to April 17, 1923. that I last saw him alive on April 17, 1923, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Cysts of Kidneys

(duration) 58 yrs. 10 mos 11 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene B. Shaw M. D.

19 (Address) JOHNS HOPKINS HOSPITAL.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sharptown, Md

DATE OF BURIAL: April 20 1923

20 UNDERTAKER: Fookler & Fookler

ADDRESS 739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74948

CERTIFICATE OF DEATH.

31 D74948

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N Central Ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Lee

(Residence in Baltimore: No. 516 N Central Ave St.; Life 35 yrs. yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 8 (Day), 1887 (Year)

7-AGE, 35 yrs. 9 mos. 21 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jacob H. Thompson

(Address)..... 516 N Central Ave.

15-

Filed 1 8 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 17 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1923, to April 17 1923, that I saw h[er] alive on April 16 1923, and that death occurred, on the date stated above, at 5 55 Am.

The CAUSE OF DEATH* was as follows:

Pulm. T.B.

(Duration) yrs. 5 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) [illegible] M. D.

April 17, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, April 19 23

20-UNDERTAKER Joseph T. H. Richter — ADDRESS 403 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-10-21—M&T—1000 Blks.

D74949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74949

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 N Bartley ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia to Klunk

(a) RESIDENCE NO. 136 N Bartley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank P Klunk

6 DATE OF BIRTH (month, day, and year) Nov 3 1569

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Lawrence Connolly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Kelley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Frank P. Klunk
(Address) 136 N Bartley

187923 Robert F. Harrison, .19....
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1923 to April 16, 1923, that I last saw h alive on April 10, 1923, and that death occurred, on the date stated above, at 1115 A m.

The CAUSE OF DEATH* was as follows:

Heart Block

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Mitral cardiac Insufficiency

(duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H. L. Hamer, M. D.

April 17, 1923 (Address) 1301 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 19 1923

20 UNDERTAKER Randall D Appel & Son — ADDRESS 378 Hm

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be complete CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

poc—12-23-21—E.B.R.S.—400 Bks.

(Lamka)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74950 D74950

CERTIFICATE OF DEATH.

74001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 307 S. Castle St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lamka

(a) Residence No. 307 S. Castel St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 1 1869

7-AGE, 54 yrs. 5 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Adam Lamka

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Catherine Lendzyon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Joseph Berdzyn

(Address) 307 S Castle St

15- APR 18 1923 19 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 16/23

17- I HEREBY CERTIFY, That I attended deceased from April 14 19 23 to April 16 19 23, that I last saw h alive on April 14 19 23, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cerebral Hemorrhage.

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Lungs

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. [illegible] M. D. 1923 (Address) 2013 Eastern St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: April 20, 1923

20-UNDERTAKER: John McWeber — ADDRESS: 1803 Bank St

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D74951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D74951

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1422 Reynolds St., 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grzegorz Sparzak.

(a) Residence No. 1422 Reynolds St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widowed

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Mary Sparzak.

6-DATE OF BIRTH (month, day and year) May 1, 1825

7-AGE. 97 yrs. 11 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) John Sparzak

(Address) 1422 Reynolds

15- APR 18 1923 192... G.G. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 18. 1923.

17- I HEREBY CERTIFY, That I attended deceased from Apr. 12 1923 to Apr. 18 1923 that I last saw h.. alive on Apr. 17 1923 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Signs

(Signed) Thos. A. Stevens, M. D.

4/18. 1923 (Address) 1878 Hayward

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Rosary	April 20. 1923
20-UNDERTAKER,	**ADDRESS**
John M Weber	1803 Bank St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Be sure to state CAUSE OF DEATH EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74952

CERTIFICATE OF DEATH.

5 1 D74952

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 W. Lafayette Ave ST., 16 WARD)

2-FULL NAME Anna Werking

(a) RESIDENCE NO. 1613 W. Lafayette Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, ~~or Divorced,~~ (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry A. Werking

6 DATE OF BIRTH (month, day, and year) Feb 8th, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER George Kuebler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Susanna Bechtel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward Werking
(Address) 1613 W. Lafayette Ave

15 Robert P. Harrison, Registrar
R 1 1923 , 19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th, 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1922 to April 16, 1923 that I last saw h[er] alive on April 16, 1923 and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Multiple abscesses Gangrene thigh

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? 1 yr - N Fullerton Md

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas R Davis M.D.

, 19 (Address) 2108 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 19? 23
20 UNDERTAKER	ADDRESS
Bertram Bros	1231 W Lafay- Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See Instructions on back of certificates.

D74953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-00 D74953

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 3723 Elm Ave. ST.: 13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John M. Henderson

(Residence in Baltimore: No.) 3723 Elm Ave. (If non-resident, give STATE.)

STATISTICAL PARTICULARS. (Yrs., 65 mos., 8 ds., 21)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word.) Married

6-DATE OF BIRTH: July (Month) 27 (Day) 1857 (Year)

7-AGE: 65 yrs. 8 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Baltimore Md

PARENTS:

10-NAME OF FATHER: David Henderson

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Eliza Smythe

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lola L. Henderson

(Address) 3535 Cedar Ave.

15- Robert F. Harrison, 191.... Registrar.

Burial Permit Clerk

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 19 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: April (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Old Age

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Dan'l Atkinson M. D.

April 18 1923 (Address) 3232 Poplar

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Mary's (Hampden) DATE OF BURIAL: April 19 1923

20-UNDERTAKER: Horace H. Burgee ADDRESS: 363 Gallo Rd.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 1954 — 31 D74954

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N. Poppleton St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Emrick

(a) RESIDENCE No. 121 N. Poppleton St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph Emrick

6 DATE OF BIRTH (month, day, and year) Feb. 14" 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Matron

(b) General nature of industry, business, or establishment in which employed (or employer) Western Police Sta

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Mc Hemmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nellie Mc Cune

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Nellie Benton

(Address) 19 S. Arlington Ave.

15 Robert F. Hartman, Registrar

1 8 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17" 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1923, to Apl 17, 1923, that I last saw h alive on Apl 17, 1923, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? He

Did an operation precede death? Date of He

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

4/18 1923 (Address) 939 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 20" 1923
UNDERTAKER Jos L B Cook	ADDRESS 1003 W Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74955

CERTIFICATE OF DEATH.

13

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Sloan Riley

(a) RESIDENCE NO. Beechwood and Summit ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Dr. R. K. Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Willie Sloan Kovats

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Records

15 Filed APR 18 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 17, 1923, that I last saw her alive on April 17, 1923 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute pyelo-nephritis

5 weeks — (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Primary (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No —

What test confirmed diagnosis? Urine examination

(Signed) A.A. Weed, M. D.

4/18 1923 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Apr. 19 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74956

CERTIFICATE OF DEATH.

11-00

D74956

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1611 W Fayett St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frank H Smith

(Residence in Baltimore: No. 1611 W Fayett St. yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Mar (Month) 25 (Day) 1879 (Year)

7-AGE. 43 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Wholesale Meats

9-BIRTHPLACE, (State or Country). Balto City.

PARENTS.

10-NAME OF FATHER. Owen K. Smith

11-BIRTHPLACE OF FATHER, (State or Country) Edmondsville Md

12-MAIDEN NAME OF MOTHER. Laura V. Walker

13-BIRTHPLACE OF MOTHER, (State or Country) Edmondsville Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gilbert Smith

(Address) 1611 W Fayett St.

15- Filed 192 Robert F. Harrison, Burial Permit Clerk. Registrar.

8823

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) following Influenza

(Duration) yrs. mos. ds.

(Signed) James H. Fenton M. D. (Coroner.)

(Address) 1005 Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. London Park Cem Apr 20 1923 DATE OF BURIAL.

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 W Balto

state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIAN should be very important. See instructions on back of certificate. Exact statement of OCCUPATION

Spec—12-23-21—E.B.R.S.—400 Bks.

D74957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74957

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 430 N. Fremont St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Zahn

(a) Residence No. 430 N. Fremont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Sing'l ~~Widowed~~, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Henry Zahn

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, about 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Athlete

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Hartford Co Md

PARENTS.

10-NAME OF FATHER, Henry Zahn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Ida Kuntz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14- (Informant) Louise Mahaffie

(Address) 208 N. Fulton Ave

15-

Filed ..... 1923 Robert P. Garrison, Registrar.

1 8 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 17-23

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1922 to Apr. 17 1923, that I last saw h. alive on Apr. 17 1923, and that death occurred, on the date stated above, at 5:-P m. The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lucas & Rahe, M. D.

4/18, 1923 (Address) 910 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, April 19 1923

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North Ave

In plain terms, so that it may be properly classified. instructions on back of certificates.

ed EXACTLY. PHYSICIANS should state CAUSE OF DEATH. ied. Exact statement of OCCUPATION is very, importa

D74958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Maryland Home for Incurables St. 90 Eutaw Ward) Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Greenwood Reus

(Residence in Baltimore: No. 2323 Barclay St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	W.	M

6-DATE OF BIRTH March 22. 1888
(Month) (Day) (Year)

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Jno. Greenwood

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. M. Fitz

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Greenwood

(Address) 2323 Barclay

15-

Filed Apr 18 1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 17. 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. Heart

Fatal Hem.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paterson. Edema. Pneumonia

(Duration) yrs. mos. ds.

(Signed) Wm. Cook M. D.

Apr 18 1923 (Coroner.) (Address) 1 E Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Westminster Md Apr. 19- 1923

20-UNDERTAKER. ADDRESS
Wm. Cook. 502 E. Monument

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D74959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 439 Pinkney Place ST., WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L Tisdale

(a) RESIDENCE No. 439 Pinkney Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Tisdale

6 DATE OF BIRTH (month, day, and year) May-18-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER John Gomeringer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Emma Gomeringer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Tisdale
(Address) 439 Pinkney Place

15 Filed ..... 19 ..... Robert F. Garrison, Registrar
Burial Permit Clerk

R 18 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18 1923 to April 18 1923.
that I last saw h[illegible] alive on April 18 1923
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) ... yrs. ... mos ... ds.
CONTRIBUTORY (Secondary) Child Birth
(duration) 2 yrs 3 mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) James M Fenton M. D.
4/18 1923 (Address) 7 W Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 20 1923

20 UNDERTAKER W. M. Cook — ADDRESS 502 E North

Dr Fenton

31

031

THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Kriton)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74960

CERTIFICATE OF DEATH.

D74960

1-PLACE OF DEATH

City of BALTIMORE: (No.) 209 Gilmor St. 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Wm Kriton

(a) Residence No. 209 Gilmor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Bell

6-DATE OF BIRTH (month, day and year) May 20 1858

7-AGE, 64 yrs. 10 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Crown Cork & Seal Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), England

PARENTS.

10-NAME OF FATHER, Henry Kriton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Mc Kinn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md Unknown

14-

(Informant) Elizabeth Kriton

(Address) 209 Gilmor St. City

15-

Filed Robert F. J. Harrison, Registrar.

01923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 16 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 17, 1922, to April 16, 1923

that I last saw him alive on April 16, 1923

and that death occurred, on the date stated above, at 10-30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chron. Nephritis

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Chas. C. Conner, M. D.

4/17, 1923 (Address) 1011 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Presbyterian Govans Phila. DATE OF BURIAL, 19, 1923

20-UNDERTAKER, Wm Cook ADDRESS 502 E 36th Ave

Filed in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks. JAMES WATSON

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74961

CERTIFICATE OF DEATH.

X 129 D74961

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Watson

(a) RESIDENCE No. Perryville Md. ST., WARD Perryville Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Watson

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Aiken Md.

PARENTS

10 NAME OF FATHER Thomas Watson

11 BIRTHPLACE OF FATHER (city or town) Aiken (State or country) Md.

12 MAIDEN NAME OF MOTHER Delia Ryan

13 BIRTHPLACE OF MOTHER (city or town) Aiken (State or country) Md.

14 Informant Florence Watson (Address) Aiken Md.

15 Filed [illegible], 19 Robert P. Harrison, Registrar

1 8 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to April 18, 1923, that I last saw h[illegible] alive on April 18, 1923, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of April 13-1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James B. Watson, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marks Aiken Md — DATE OF BURIAL 4/21/1923

20 UNDERTAKER Wm. Cooke - 502 E. North Ave. ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74962 CERTIFICATE OF DEATH. 161-001 D74962

1-PLACE OF DEATH Baltimore Md Registered No.....

City of BALTIMORE: (No 439 Pickney St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Tisdale

(a) Residence No. 439 Pickney Place St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 17 1923

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 2 hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, William C Tisdale

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Stanton Va

12-MAIDEN NAME OF MOTHER Emma Gomeringer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) William C Tisdale

(Address) 439 Pickney Place

15- Filed.....Robert F. Garrison, 19.....Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/17/23

17- I HEREBY CERTIFY, That I attended deceased from April 17 1923 to April 17 1923.

That I last saw her alive on April 17 1923,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth, T.
Atrophied Placenta

(Duration) .....yrs. mos. 2 hrs

CONTRIBUTORY (Secondary) Tuberculosis Mother (Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Kenton, M. D.

1923 (Address) 709 Chanel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Apr 20 1923
20-UNDERTAKER.	ADDRESS
Wm. Cook	502 E. North Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Joseph A Hauser

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74963

CERTIFICATE OF DEATH.

X 128

REGISTERED NO. D74963

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Monrow Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. Hauser

(a) RESIDENCE NO. 306 River St Hoboken NJ WARD New York.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Marine

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Australia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Patients History
(Address)

15 APR 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-5, 1923, to 4-17, 1923, that I last saw him alive on 4-16, 1923, and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Nephritis, parenchymatous Acute

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) P. E. Schaale, M. D.

4/17 1923 (Address) Monrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL 4/19 1923

20 UNDERTAKER S. Levinson's Bro — ADDRESS 112 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74964

CERTIFICATE OF DEATH.

31 D74964

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 S 7th ST., 720 WARD)

2-FULL NAME Harry M. Clarkey.

(a) RESIDENCE NO. 408 S 7th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Berg

6 DATE OF BIRTH (month, day, and year) Apr 7-1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	—	12	

8 OCCUPATION OF DECEASED Ann Can Co

(a) Trade, profession or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas E Mc. Clarkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna Gurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mamie Mc Clarkey
(Address) 708 S. 7th St

15 FILED APR 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/11/23, 1923, to 4/16/23, 1923
that I last saw h[illegible] alive on 4/16, 1923
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Cardiac decompensation
Tuberculosis pulm

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Hamel H Wiehle, M. D.
, 19 (Address) 928 Rutland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem — DATE OF BURIAL Apr 19 1923

20 UNDERTAKER John Ullrich — ADDRESS [illegible]

Spec—12-23-21—E.B.R.S.—400 Blks.

D74965 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D74965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 115 Overhill Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John Handy Waller

(a) Residence No. 115 Overhill Road St., 27 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 57 yrs. 3 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edith W. Waller

6-DATE OF BIRTH (month, day and year) Jan-16-1872

7-AGE, 51 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Newspaper Editor

(b) General nature of industry, business, or establishment in which employed (or employer)..... Baltimore Sun

(c) Name of employer..... A. S. Abell Company

9-BIRTHPLACE (city or town) (State or Country), Salisbury Md

PARENTS.

10-NAME OF FATHER, Thos W. Waller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Sussex Co. Delaware

12-MAIDEN NAME OF MOTHER, Mary A. Mitchell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Salisbury City Maryland

14- (Informant) Mrs Edith W. Waller (wife)

(Address) 115 Overhill Road

15- Filed APR 19 1923 19?

ROBERT R. KRAUTER, DEPUTY REGISTER.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19/23

17- I HEREBY CERTIFY, That I attended deceased from April 6th 1923 to April 19 1923

that I last saw him alive on April 19 1923

and that death occurred, on the date stated above, at 4-a m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) 0 yrs. 0 mos. 18 ds.

CONTRIBUTORY (Secondary) Emphysema

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Gordon Linton M. D

4/19. 1923 (Address) 49 Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL. April 20 1923

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCC instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74966

CERTIFICATE OF DEATH.

100-001 D74966

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 650 Haw ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Lee Dotson

(a) RESIDENCE NO. 650 Haw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb - 10 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	—	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER James Dotson

11 BIRTHPLACE OF FATHER (city or town) Winnsboro
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Hattie Davis

13 BIRTHPLACE OF MOTHER (city or town) Winnsboro
(State or country) South Carolina

14 Informant James Dotson
(Address) 650 Haw St

15 APR 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr, 12, 1923, to Apr, 17, 1923, that I last saw her alive on Apr, 17, 1923, and that death occurred, on the date stated above, at 2:55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia
(Primary)
(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) David Druecker M. D.

4/18, 1923 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	April 19 1923
20 UNDERTAKER Edward Bryan	ADDRESS 631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74967

CERTIFICATE OF DEATH.

21 ✓ D74967

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 N. Eden ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha V. Brown

(Residence in Baltimore: No. 527 N Eden St.; 8 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. ? (Month) ? (Day), 1890 (Year)

7-AGE, 33 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md. Baltimore

PARENTS.

10-NAME OF FATHER, Samuel Chase

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Julie Johnson ~~Thomp~~

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Chase (Brother)

(Address) 527 N. Eden St

15- Filed APR 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 17 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1923, to April 17 1923, that I saw her alive on April 16 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Septic throat

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. J. Young M. D.

4/19, 1923. (Address) 14 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount & St Stephens — DATE OF BURIAL, April 22, 1923

20-UNDERTAKER Edward Bryan — ADDRESS 631 Orleans St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74968

CERTIFICATE OF DEATH.

5 100-001

D74968

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 215 N. Central Ave St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. W. Jones

(Residence in Baltimore: No. 215 N. Cent. Ave St.; 4 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (write the word.)
male	col.	d[illegible]

6-DATE OF BIRTH. Feb 2/23 ..... 1.....
(Month) (Day) (Year)

7-AGE. ..... yrs. 2 mos. 19 ds. | If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). MD.

PARENTS.

10-NAME OF FATHER, John J. Jones

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Parthenia Figgs

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Jones

(Address) 215 N. Cent. Ave

15. APR 19 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18/23 ....., 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said .....
inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchopnuemonia (Primary)

.....(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Paen M. D.
(Coroner.)
4/19/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	April 21 1923
20-UNDERTAKER.	ADDRESS
Milton Davis	315 N Eden St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74969

CERTIFICATE OF DEATH.

161-001

D74969

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 S. Curley ST., 1 WARD)

2-FULL NAME Mary Bamberger

(a) RESIDENCE NO. 637 S. Curley ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15 1923

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Bamberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Downey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Margaret Bamberger (Address)

15 Filed APR 19 1923 ROBERT R. KRAUSLICH Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to April 15, 1923, that I last saw her alive on April 15, 1923 and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

6 month Foetus

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Frances B Sitlow M. D.

4/18, 1923 (Address) 314 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johns Hopkins Embry Dept — DATE OF BURIAL: 4/16 1923

20 UNDERTAKER — ADDRESS

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D74970 HEALTH DEPARTMENT—CITY OF BALTIMORE B74970

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Race ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie G. Queen

(a) RESIDENCE. No. 1115 Race ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

IF DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, the entry should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Grafton Queen

6 DATE OF BIRTH (month, day, and year) Sept 16th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) D. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Annie Dixon

(Address) 1115 Race St.

15 Filed APR 19 1923 19.. ROBERT R. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1923 to April 17 1923, that I last saw her alive on April 16 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema
Congestion

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tbc

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Ruth Boteler M. D.

April 18th 1923 (Address) 908 E Shore Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	April 20 1923

20 UNDERTAKER I. H. Blount & Son ADDRESS 1010 W Monty-

Spec. - 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74971

CERTIFICATE OF DEATH.

31 D74971

D74971
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 S. Howard ST., 23 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Henry Waters

(a) RESIDENCE No. 1023 S. Howard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Waters

6 DATE OF BIRTH (month, day, and year) Apr. 2. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	46	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Driver 23

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer George Bucci

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER William Waters

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Virginia

14 Informant Louise Waters
(Address) 1023 S. Howard St

15 APR 19 1923 Filed ....., 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 8, 1923, to Apr. 18, 1923, that I last saw him alive on Apr. 17, 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis -

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Nephritis (duration) yrs. mos. ds. (uncertain)

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum +

(Signed) Davis Trueblood M. D.

4/16. 1923 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	April 21 1923
20 UNDERTAKER	ADDRESS
J. L. Bromwell Son	108 W Mount'g

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74972

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1469 Reynolds. ST., 24 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene E. Livesay

(a) RESIDENCE NO. 1469 Reynolds ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day,.... hrs. or .... min.
	2	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Walter Livesay

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Christine Martell

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Walter Livesay
(Address) 1469 Reynolds.

15 Filed APR 19 1923 ..... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17 I HEREBY CERTIFY, That I attended deceased from apr 14, 1923, to April 18, 1923.

that I last saw her alive on April 18, 1923.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? (over)

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens, M. D.

4/19/1923 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loby Rosary.

DATE OF BURIAL April 19 1923

20 UNDERTAKER John M Weber

ADDRESS 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pharyngeal - Nasal - Tonsillar

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74973

CERTIFICATE OF DEATH.

161-001 D74973

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 116 W. Clinton ST. 26 WARD)

2-FULL NAME Infant of Ethel M. and Nora Bell Hall

(a) RESIDENCE NO. 116 W. Clinton ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) April 18 1923

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Ethel M. Hall

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Nora Bell Bailey

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Ethel M. Hall (Father)
(Address) 116 W. Clinton St.

Filed APR 19 1923. 19 ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to April 18, 1923, that I last saw her alive on April 18, 1923, and that death occurred, on the date stated above, at 5.00 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Term + Half month
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. C. Eigan, M. D.

4/19/23 (Address) 390 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 19 23

20 UNDERTAKER Lilly + Zeiler

ADDRESS 4033 Woodland

Spec.—1-10-21—M&T—1500 lbs.

D74974 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D74974

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 S. Patterson Pk Ave ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Callahan

(a) RESIDENCE NO. 426 S. Patterson Pk Ave ST., 1 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late James Callahan

6 DATE OF BIRTH (month, day, and year) Oct 7th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Bernard Comber.

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Ann Birmingham

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Nora Comber Martin
(Address) 223 S. Ann St.

15 Filed APR 19 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to April 17, 1923, that I last saw her alive on " 17, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. D. Neer, M. D.

4/18/23 (Address) 408 S Pat Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Loudon Park National Cemetery	April 20th 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4035 Wolfe St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D74975

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Silinski (Silinskas)

(a) RESIDENCE NO. 426 S. Paca St; ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

THIS SPACE FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unmarried

6 DATE OF BIRTH (month, day, and year) Aug. 4, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country)

PARENTS

10 NAME OF FATHER Jno. Silinski

11 BIRTHPLACE OF FATHER (city or town) Lithvania (State or country)

12 MAIDEN NAME OF MOTHER Barbor Ozunas

13 BIRTHPLACE OF MOTHER (city or town) Lithvania (State or country)

14 Informant: University Hospital Records (Address)

15 FILED APR 19 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17

I HEREBY CERTIFY, That I attended deceased from 4/17, 1923, to 4/18, 1923,

that I last saw him alive on 4/18, 1923,

and that death occurred, on the date stated above, at 7:45 p. m.

The CAUSE OF DEATH* was as follows:

Empyema, right, gd

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/17/23

Was there an autopsy? No

What test confirmed diagnosis? Thoracotomy.

(Signed) Robt. K. Hooper, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislowas — DATE OF BURIAL: April 21, 1923

20 UNDERTAKER: John Grebliauckas J.G. — ADDRESS: 425 S. Paca St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchis Pneumonia
Primary

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74976

CERTIFICATE OF DEATH.

3/ D74976

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2844 Harlem Ave. St., 16 Ward)

2-FULL NAME. William G. Eckert,

(a) RESIDENCE. No. 2844 Harlem Ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Gertrude Eckert

6 DATE OF BIRTH (month, day, and year) June 28-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Meat Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): U. S. Government

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Henry Eckert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Gertrude Eckert, (wife)
(Address) 2844 Harlem Ave.

15 Filed . 19 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

APR 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17th 1923

17 I HEREBY CERTIFY, That I attended deceased from August 5. 1922. to April 17th. 1923.
that I last saw alive on April 16th. 1923.
and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Amelia E Link, M. D.

. 19 (Address) 1717 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	4/20/1923

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D74977

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

24 159-002

D74977

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 Cooksie St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Joseph Maiewski.

(Residence in Baltimore: No. 1313 Cooksie St. St.; yrs., ---------- mos. 3. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. April 15, 1923. (Month) (Day) (Year)

7-AGE. ---- yrs. -- mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. James Maiewski.

11-BIRTHPLACE OF FATHER, (State or Country). Poland.

12-MAIDEN NAME OF MOTHER. Frances Smolsky.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Maiewski. (mother).

(Address) 1313 Cooksie Street.

15- Filed APR 19 1923. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Apr. 18, 1923. (Address) 1017 E. Charles St.

*State the **Disease Causing Death**, or, In deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	April 19, 1923
20-UNDERTAKER.	ADDRESS
John M. Weber	1803 Bank

Spec.—1-10-21—M&T—1500 Bks.

162,978 D74,978

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-003 D74978

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Howowes ki (Nowowes ki)

(a) RESIDENCE No. 2511 Fleet St. City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) April 11, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	0	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: 0

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Walter Howowes ki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Frances Atmonsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: JOHNS HOPKINS HOSPITAL. (Address) Records

15 APR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 15, 1923, that I last saw him alive on April 15, 1923, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Spina Bifida with meningocele

congenital (duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Meningitis (pyogenic) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X

(Signed) A. A. Weed, M. D.

. 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: 4/20 1923

UNDERTAKER: Wm Fialkowski — ADDRESS: 418 Parkin Ave

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74979 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D74979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 2 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Popowiez

(a) RESIDENCE NO. 630 S. Wolfe St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 8 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Popowicz,

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wojciech Filipowicz,

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Elezabeth Szymanski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Municipal Hospital Records.
(Address)

15 Filed APR 19 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 19 23

17 I HEREBY CERTIFY, That I attended deceased from April 4, 19 23, to April 18, 19 23

that I last saw her alive on April 17, 19 23

and that death occurred, on the date stated above, at 1:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Lobular Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of no

Was there an autopsy? yes Pathological Examination

What test confirmed diagnosis?

(Signed) L. M. Shipley M. D.

4-18-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cemetery — DATE OF BURIAL: Apr. 20. 19 23

20 UNDERTAKER: W. F. Sadowski — ADDRESS: 705 S. ANN St

PRINTED, WITH PENDING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74980 D74980

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital (STREET OR AVENUE) WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Waters

(a) RESIDENCE NO. 24 E Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of John Waters

6 DATE OF BIRTH (month, day, and year) June 19-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Rev Mathias Forbes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Martha Street

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanford Co Md

14 Informant Mrs Mary H Abell

(Address) 609 Washington Place

15 Filed APR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17 I HEREBY CERTIFY, That I attended deceased from apr 17, 1923 to apr 18, 1923.

that I last saw her alive on apr 18, 1923.

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

chronic nephritis

not known (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James Hunt Wilkinson M. D.

19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL April 20 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Wath

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D74981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 47 D74981

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius Jarboe

(a) RESIDENCE NO. Chesterfield Md. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown. Minerva C. Jarboe

6 DATE OF BIRTH (month, day, and year) May 2 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	66	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Jarboe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anne Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records

(Address)

15 Filed APR 19 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 19, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1923, to Apr. 19, 1923.

that I last saw him alive on Apr. 19, 1923.

and that death occurred, on the date stated above, at 1.20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Left breast

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4-12-23.

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) J. M. K. Rodda, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL April 21. 1923.

20 UNDERTAKER Wm. Cook - Sons & Hartwood ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D74982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D74982

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 W. Clement ST. 23 WARD)

2-FULL NAME Frank Assmann

(a) RESIDENCE NO. 108 W. Clement St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Assmann

6 DATE OF BIRTH (month, day, and year) Nov. 11 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Court House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Assmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Filling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Edwin F. Thornton 108 W. Clement St.

15 FILED APR 19 1923 ROBERT R. KRAUTER, Asst. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/1/, 1923, to 4/18, 1923, that I last saw h m alive on April 18- 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo Carditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. W. Mayson, M. D.

19 (Address) 827 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL April 21 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74983

CERTIFICATE OF DEATH.

13 D74983

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 N. Bradford ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian L Snow

(a) RESIDENCE No. 1711 N Bradford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Clyde W Snow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Minnie F Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Camden N.J.

14 Informant Clyde W Snow (Address) 1711 N Bradford St

15 APR 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 18, 1923, that I last saw her alive on April 17, 1923, and that death occurred, on the date stated above, at 5 15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mumps

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) B P Herzog M. D.

Apr 18 1923

(Address) 1305 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL Camden Park Cem — DATE OF BURIAL 4/19 1923

18 UNDERTAKER Jno F Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D74984

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 S. 13th ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Johnson

(a) RESIDENCE NO. 415 S. 13th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clyde Johnson

6 DATE OF BIRTH (month, day, and year) Apl 19 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Edgemere (State or country) Balto. Co

PARENTS

10 NAME OF FATHER Henry O. Bullen

11 BIRTHPLACE OF FATHER (city or town) West River (State or country) A.A.Co. Md

12 MAIDEN NAME OF MOTHER Lavinia Wilbis

13 BIRTHPLACE OF MOTHER (city or town) Kent Co (State or country) Maryland

14 Informant Russell Bullen (Address) 230 Patapsco Ave. St Helena Md

15 Filed APR 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/5/23, 19 . to 4/18/23, 19 .

that I last saw h[illegible] alive on 7/18/23, 19 ;

and that death occurred, on the date stated above, at 5^a A. m.

The CAUSE OF DEATH* was as follows:

Pul T Tuberc

(duration) [illegible] yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? [illegible]

(Signed) Dora Whitney, M. D.

4/19, 1923 (Address) 710 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cemetery DATE OF BURIAL April 20 1923

20 UNDERTAKER John T Denny ADDRESS 715 Light St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74985

CERTIFICATE OF DEATH.

118-002 D74985

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 E. Eager ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Killalea

(a) RESIDENCE NO. 808 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	68	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos. Killalea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Stephen Burke

(Address) 808 E. Eager St.

15 APR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to April 17, 1923, that I last saw her alive on April 17, 1923, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Intestinal Abstruction

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Signs + Symptoms

(Signed) Mary T. Voeglein, M. D.

4. 18. 1923 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters — DATE OF BURIAL: Apr. 20 1923

20 UNDERTAKER: H. C. Friedfeld — ADDRESS: 917 Fremont Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Rbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74986

CERTIFICATE OF DEATH.

D 71986

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Clark Fenton

(a) RESIDENCE NO. Park Heights Ave 3houses N 7mile lane ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? 68 yrs. 2 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or WIFE of Harriet Thomas Fenton

6 DATE OF BIRTH (month, day, and year) Jan. 29 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Paper

(b) General nature of industry, business, or establishment in which employed (or employer) Paper

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Aaron Fenton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington Pa.

12 MAIDEN NAME OF MOTHER Rebecca Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mr. J. Norman Fenton (brother)

(Address) 1421 Bolton Street.

15 APR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19- 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1923, to Apr 19, 1923, that I last saw him alive on Apr 19, 1923, and that death occurred, on the date stated above, at 4^15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
secondary to operation

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? 2,

Did an operation precede death? Yes Date of Apr 14 1923

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J.B. Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	April 23.
20 UNDERTAKER MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X74-001 D74987

D74987

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 N Stricker ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Osko. Shipley.

(a) RESIDENCE NO. 1 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White	Widower

5a ~~If married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Elara. Shipley

6 DATE OF BIRTH (month, day, and year) Aug 8 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Robert Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elenora Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Florence Stens

(Address) 1 N Stricker St

15 Filed APR 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 17, 1923, that I last saw him alive on April 17, 1923, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. S. L. Campbell, M. D.

(Address) 1626 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Ville Md. DATE OF BURIAL 4-20 1923

20 UNDERTAKER Ehrb Hale ADDRESS 115 E West St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74988

CERTIFICATE OF DEATH.

129 D74988

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Julia Brooks

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address) UNIV

15 Filed APR 19 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from February 10, 1917, to April 16, 1923, that I last saw her alive on April 15, 1923, and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

chronic nephritis &
hypertension

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) H Mead, M. D.

4-16 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 19 1923

Per. Wm. E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74989

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74989

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital No. ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sheehan

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE: Years 49 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: //

11 BIRTHPLACE OF FATHER (city or town) (State or country): //

12 MAIDEN NAME OF MOTHER: //

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant .....
(Address) .....

15 Filed ..... 19 ..... Registrar

R 24 1923 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1923, to April 16, 1923, that I last saw him alive on April 16, 1923 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(Lentic) (duration) ... yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary) Paresis & Alcoholism

? (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinical

(Signed) J. A. McKay, M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS APR 19 1923

For Wm. B. [illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74990

CERTIFICATE OF DEATH.

74-001 D74990

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 S. Clinton ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Appel

(a) RESIDENCE NO. 1125 S. Clinton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Appel

6 DATE OF BIRTH (month, day, and year) Jan. 27-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Busz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Scharman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katharine Deuchler

(Address) 1125 S. Clinton St.

15 Filed ..... 19 ..... Robert T. Harrison, Registrar

Burial Permit Clerk.

R 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17

I HEREBY CERTIFY, That I attended deceased from April 8th. 1923, to April 17th. 1923, that I last saw h[illegible] alive on April 17th. 1923, and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Apoplexy

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. W. Jones M. D.

4/18/1923 (Address) 1011 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL April 20 1923

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St.

INFORMATION CONCERNING THIS RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D74991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74991

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Bellona & Charles (New)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Villa ST., 27 WARD)

2-FULL NAME Ellen R. Heatherman

(a) RESIDENCE NO. Mercy Villa ST., ... WARD Huntington W. Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Heatherman

6 DATE OF BIRTH (month, day, and year) Feb. 10, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10 NAME OF FATHER Dennis Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Regina H. Boyle

(Address) Washington, D. C.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 19, 1923, that I last saw h[illegible] alive on April 18, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Chr. Nephritis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Huntington W Va

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical & Lab.

What test confirmed diagnosis?

(Signed) Hardey G Beal M. D.

, 19 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Huntington, W. Va.	Apr. 19, 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 Calvert St

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74992

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74992

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hos. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Walter

(a) RESIDENCE No. 1500 Eutaw Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Walter

6 DATE OF BIRTH (month, day, and year) Oct. 2 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jewelry Bus.

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer 045

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Hotzig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eugene N. Walter

(Address) 1500 Eutaw Place

15 R 19 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 9, 1923, to April 17, 1923, that I last saw he alive on April 17, 1923, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Thrombosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) C Lumpenmeyer, M. D.

19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Apr. 20 1923
20 UNDERTAKER	ADDRESS
Wm Tuckner & Son	Norfolk Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74993

CERTIFICATE OF DEATH.

74-002 D74993

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Notre Dame College

CITY OF BALTIMORE: (No. Charles St., 27 Ward)

2-FULL NAME Mary Blandina Scheidell

(a) RESIDENCE No. Notre Dame College St., 27 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26- 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Imbsloch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kaiserslautern Germany

14 Informant Sister M. Philomel (Address) Charles Street Ave.

R 19 1923 Robert F. Harrison, .19.....

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1923, to Apr 17, 1923.

that I last saw her alive on April 17, 1923

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cardiac & Cerebral Embolus.

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Phlebitis 7

Septicemia (Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Jones, M. D.

4/16 1923 (Address) 402 Hanover Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govenstown. Private lot	April 20 1923
20 UNDERTAKER	ADDRESS
Frank A. Fink	916 W. Gay

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74994 ✓ 90 D74994

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kelly

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer 0

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Wm. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Municipal Hospital Records.

(Address)

15 Filed ....., 19 ..... Registrar

Burial Permit Clerk.

APR 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 19 23

17

I HEREBY CERTIFY, That I attended deceased from April 16, 19 23, to April 17, 19 23,

that I last saw him alive on April 17, 19 23,

and that death occurred, on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 wk ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. A. McKay, M. D.

4-18-23 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Antrim	Apr 20 1923
20 UNDERTAKER	ADDRESS
Brown Funeral Home	1129 Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74995

CERTIFICATE OF DEATH.

101-001 D74995

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 254 N. Bruce. ST.: 19 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Weaden

(a) RESIDENCE. No. 254 N. Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 8 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Col	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John Weaden.

6 DATE OF BIRTH (month, day, and year) July-26-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house-wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER George Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co; Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: John Weaden
(Address): 254 N. Bruce St.

15 Filed 4 19 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 - 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 17-, 1923; that I last saw h.er alive on April 16-, 1923; and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chester Riland, M. D.

4-18, 1923 (Address) 253 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	April 19 1923
20 UNDERTAKER	ADDRESS
Draper & Packard	Schroder

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74996

D74996

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2810 Elliott ST., 1 WARD)

2-FULL NAME Genevieve Mitchell

(a) RESIDENCE NO. 2810 Elliott ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 22 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) schoolchild

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Walter T Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raiford Fla

12 MAIDEN NAME OF MOTHER Lee Germaine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Walter T Thomas (Address) 2810 Elliott

15 Apr 19 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1923. to April 17. 1923.

that I last saw h alive on April 17. 1923,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Uremia - Nephritis

Cardiac dilatation.

over

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Mitral insufficiency -

Cardiac hypertrophy (duration) ... yrs. 2 mos. 2 days

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. W. Wright M. D.

7/18. 1923 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemt

DATE OF BURIAL April 20, 1923

20 UNDERTAKER Wm Cook

ADDRESS 506 E Nor

NOTICE—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: ***Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.*** The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Could give no other
Cause Para a Pulmonary
of Edema

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74997

CERTIFICATE OF DEATH.

129 D74997

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Farris

(a) Residence No. 928 Boyd St. St., Ward

(Usual place of abode) about

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of R

6-DATE OF BIRTH (month, day and year) ~~1882~~

7-AGE. 41 22? yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Factory work

(b) General nature of industry, business, or establishment in which employed (or employer): S

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Archy Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

11- (Informant) Municipal Hospital Records

(Address)

15- 19 Robert P. Harrison, Registrar.

PR 19 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 17, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 14, 19 23 to April 17, 19 23.

that I last saw him or alive on April 17, 19 23.

and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's & Dropsy

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

4-17-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	April 20 19 23
20-UNDERTAKER.	ADDRESS.
Brown & Richards	Lexington

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D74998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D74998

10

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer C. Griffin

(a) RESIDENCE NO. 2612 Lehman St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	2	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER E. C. Griffin

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Evans

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Mother - Mrs. E. C. Griffin
(Address) 2612 Lehman St

15

PR 19 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19/23

17

I HEREBY CERTIFY, That I attended deceased from 4/18, 19 23, to 4/19/23, 19 ,

that I last saw him alive on 4/19/23, 19 ,

and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? pos. culture

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL April 19 1923

20 UNDERTAKER Robt F Jarrett — ADDRESS 1442 Broadway

MATTER IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D74999

HEALTH DEPARTMENT—CITY OF BALTIMORE D74999

CERTIFICATE OF DEATH.

71-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Burt

(a) RESIDENCE No. Mannington W. Va. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 6, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Fred Burt

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Nina Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address) Baltimore.

15 Apr 19 1923 Robert P. Harrison, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to April 19, 1923, that I last saw him alive on April 19, 1923 and that death occurred, on the date stated above, at 1.40 a.m.

The CAUSE OF DEATH* was as follows:

Brain Abscess, right occipital

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of apr 17

Was there an autopsy? By Pathologist

What test confirmed diagnosis? Operation

(Signed) H. K. Reichert, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mannington W Va	April 19 1923
20 UNDERTAKER	ADDRESS
Joseph ahrens	220 Busy

P.S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 191923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75000 ✓ X31 D75000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. VETERANS' HOSPITAL #56, FT. MCHENRY, BALTIMORE, Md.

CITY OF BALTIMORE: (No. ..... ST., 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME BASS, Beryl

(a) RESIDENCE No. 1134 Eoff St. Wheeling, W.Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, [illegible]
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	21	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician (French Horn)

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown --

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown --

14 Informant Hospital Records

(Address) Fort McHenry, Baltimore, Md.

15 Filed ..... 19 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1923

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1922, 19 ..., to April 19, 1923, 19 ..., that I last saw him alive on April 19, 1923, 19 ..., and that death occurred, on the date stated above, at 1:00 A.M. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary chronic far advanced and active

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Constitutional psychopathic State Emotional Instability. Matoiditis chr. Fistula in ano, tubular. Spt. Pneumonia-Thorax left.

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Positive sputum T.B.

(Signed) H. H. Barker, Jr. Surgeon R. ..... M. D.

4/19/23 (Address) Fort McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Littleton W. Va	4/19 1923
20 UNDERTAKER E. Lunsford & Bro	ADDRESS 1127 E Baltimore St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS

D75001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181 D75001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 404 Forest St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Domenico Lucarini

(Residence in Baltimore: No. ~~4100~~ 404 Forest St.; 12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH. June (Month) 12 (Day) 1887 (Year)

7-AGE. 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Lab

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Andrea Lucarini

11-BIRTHPLACE OF FATHER, (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Teresa Lucarini

13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) 123 h. Front Street

15- APR 19 1923 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 17 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon monoxide poisoning

Sudden accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W J Riley M. D.

(Coroner.)

April 19 192 (Address) 1630 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 4/20 19 23

20-UNDERTAKER, George J Ruth ADDRESS 1735 Hanford Ave

R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and others state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75002

CERTIFICATE OF DEATH.

31 D75002

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1157 N. Calhoun ST.; 16 WARD)

2-FULL NAME Mamie Williams

(a) RESIDENCE. No. 1157 N. Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Enoch Williams

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE — Years: 37 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Marys Co Maryland.

PARENTS

10 NAME OF FATHER: James Holley.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Tarrant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Enoch Williams 1157 Calhoun St.

15 [illegible] APR 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 24th, 1923, to April 18th, 1923
that I last saw h[illegible] alive on April 18th, 1923
and that death occurred, on the date stated above, at 11.00 a. m.
The CAUSE OF DEATH* was as follows:

Acute Pneumonia Phthisis
following Influenza
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Typical.

(Signed) Jno. N. Lautenbach . M. D.

4-18 1923 (Address) 2215 N. Monroe Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters — DATE OF BURIAL: April 21 1923

20 UNDERTAKER: James H. Dennis — ADDRESS 213 Dunbar

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75003

CERTIFICATE OF DEATH.

90 D75003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Lorman St ST.; 15 WARD)

2-FULL NAME George H Taylor

(a) RESIDENCE. NO. 1615 Lorman St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Taylor

6 DATE OF BIRTH (month, day, and year) June 4, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Hod-carrier) 035

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex Co., Va.

PARENTS

10 NAME OF FATHER Jerry Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co., Va.

12 MAIDEN NAME OF MOTHER Amanda Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co., Va.

11 Informant Virginia Taylor (Address) 1615 Lorman St.

15 APR 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18- 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-8, 1923, to 4-18, 1923, that I last saw h~~im~~ alive on 4-16-, 1923, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Volvular Heart Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	April 21, 1923
20 UNDERTAKER James W. Dennis	ADDRESS 1312 Gilmor

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

162931, D75004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D75004

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST., 6 WARD)

JOHNS HOPKINS HOSPITAL

2-FULL NAME Annie Crook

(a) RESIDENCE NO. 116 N. Anne St. ST. City WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~: Mollie (Daughter).

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 35; Months ?; Days ?; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H.W. 037

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: .....

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country): .....

14 Informant (Address): JOHNS HOPKINS HOSPITAL Records

15 Filed APR 20 1923 ROBERT P. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1923, to April 19, 1923, that I last saw h[illegible] alive on April 19, 1923 and that death occurred, on the date stated above, at 11 40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma esophagus

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of April 18 '23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Emil Holman, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nehsen Rosedale — DATE OF BURIAL 4/20 1923

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75005

CERTIFICATE OF DEATH.

44 D75005

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Ruxton ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Diana Mertenbaum

(Residence in Baltimore: No. 1811 Ruxton ave St.; 20 yrs., 11 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Oct (Month) ..... (Day), 1860 (Year)

7-AGE, 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 604

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham D. Lampford

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saul Mertenbaum

(Address) 1811 Ruxton ave

15-

Filed APR 20 1923 ROBERT R. KRAUTER, 151

Burial Permit ~~Clerk~~.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 19 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 6 1923, to April 18 1923, that I saw h er alive on April 18 1923, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

.....

.....

Gastric Carcinoma

..... (Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Hollman M. D.

April 19, 1923 (Address) 1576 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lehren Rosedale | DATE OF BURIAL, April 20, 1923

20-UNDERTAKER Jack Lewis 1429 | ADDRESS Eastern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75006

CERTIFICATE OF DEATH.

162

D75006

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST., 3 WARD)

2-FULL NAME Baby Friedman

(a) RESIDENCE NO. 308 S. Carlin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-18-23

7 AGE — Years — Months — Days — If LESS than 1 day, 14 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Baltimore

15 FILED APR 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1923

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to April 19, 1923, that I last saw him alive on April 18, 1923, and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest B. Edwards, M. D.

4-19, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Interment — DATE OF BURIAL: 4-19 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75007

CERTIFICATE OF DEATH.

100-00 D75007

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 N. Hare ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Boram

(a) RESIDENCE NO. 113 N. Hare ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert Boram

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Anna Ott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Albert Boram
(Address) 113 N. Hare St

15 Filed APR 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 13, 19 23, to Apr 19, 19 23, that I last saw her alive on Apr 19, 19 23 and that death occurred, on the date stated above, at 6 15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

1 wk (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) B O'Kelly M. D.

, 19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Cem.	April 20 1923
20 UNDERTAKER L. Sander Sons	ADDRESS 1720 Pratt St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75008

CERTIFICATE OF DEATH.

128

D75008

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6365 Belnord St., 1 Ward)

2-FULL NAME William C Miller

(a) RESIDENCE NO. 636 Belnord Ave St., 1 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Catherine Miller

6 DATE OF BIRTH (month, day, and year): April 18 1859

7 AGE: Years 64; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Canners

(c) Name of employer: W W Boyer & Co

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Miller
(Address) 636 S. Belnord Ave

15 Filed APR 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1923, to April 18, 1923, that I last saw him alive on April 18, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Roland Strahan, M. D.

1923 (Address) 532 S Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Cemetery — DATE OF BURIAL: April 22 1923

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Alcoholic
Exposure

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75009

CERTIFICATE OF DEATH.

129 D75009

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 Richmond ST., 11 WARD)

2-FULL NAME Matilda Harris

(a) RESIDENCE No. 132 Richmond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Harris

6 DATE OF BIRTH (month, day, and year) [redacted]

7 AGE 38	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Geo. Harris 132 Richmond St

15 APR 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1923, to Apr. 17, 1923,

that I last saw h[illegible] alive on Apr. 17, 1923, 3:30 P. m.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Virginia

Chronic interstitial (duration) yrs. 1 mos 5 da.

CONTRIBUTORY (Secondary) nephritis (duration) yrs. 4 mos. ∇ da.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) John H. Thompson M. D.

19 (Address) 1014 Dulaney Valley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4/20 1923

20 UNDERTAKER Sam'l F. Hamilton

ADDRESS 578 Park Ave

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75010

CERTIFICATE OF DEATH.

179 D75010

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 Edgevale Road- Roland Park ST., 27 WARD)

2-FULL NAME Ellen F. Stebbins

(a) RESIDENCE NO. 212 Edgevale Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Stebbins

6 DATE OF BIRTH (month, day, and year) Aug. 17, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Alexander S. Steuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Ellen Jane Fraser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Charles W. Stebbins (Address) 212 Edgevale Road

15 FILED APR 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 a 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Apl. 18 a 1923.

that I last saw h alive on Apl. 18 a 1923,

and that death occurred, on the date stated above, at 9.15 p m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ch. Valv. Endocarditis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jefferis Busey M. D.

4/19, 1923 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/20/23 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

D75011 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D75011

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 240 Bowers Ct St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gilbert

(Residence in Baltimore: No. 240 Bowers Ct St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: May 8 1922 (Month) (Day) (Year)

7-AGE: yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: John Gilbert

11-BIRTHPLACE OF FATHER, (State or Country): Balto City

12-MAIDEN NAME OF MOTHER: Mary Moore

13-BIRTHPLACE OF MOTHER, (State or Country): Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sara Moore

(Address) 1006 Sarah ann

15- APR 20 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18 (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Kenton M. D. (Coroner.)

April 19 192 3 (Address) 700 Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Carmen Cem — DATE OF BURIAL: April 20 1923

20-UNDERTAKER: Dent Eagan's — ADDRESS 916 Pine

Spec.—1-10-21—MAT—1500 Blks.

D75012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160

D75012

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 14 WARD)

2-FULL NAME Robert Burch.

(a) RESIDENCE No. St. Vincents Inf. Asy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Bertha Burch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant St Vincent Inf Asylum

(Address) 401 Division St

15 Filed APR 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-13, 1923, to 4-18, 1923,

that I last saw him alive on 4-18-, 1923,

and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Emaciation

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Edward A. Kitlowski, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	4/20. 1923
20 UNDERTAKER Martin Kahey & Son	ADDRESS 832 W Pratt

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bka.

D75013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75013

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3134 O'Donnell ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur A. Ey

(a) RESIDENCE. No. 3134 O'Donnell ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 2 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER William F. Ey

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Lohman

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Louisa Ey.
(Address) 3134 O'Donnell St.

Filed APR 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19th 1923

17

I HEREBY CERTIFY, That I attended deceased from April 15th 1923, to April 19th 1923, that I last saw him alive on April 19th 1923, and that death occurred, on the date stated above, at 6m P. m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia, Generalized Septicaemia, Double Otitis Media Purulent, Abscessed L. Arm Leg & Chest (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Measles & Chickenpox (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Nothing Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) L. N. Linton Cliff M. D.

4/20, 1923 (Address) 1312 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	April 20 1923
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 E. Eager

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE CLEARLY, WITH UNFADING INK—

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75014

CERTIFICATE OF DEATH.

D75014

90

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H. Walker

(a) RESIDENCE NO. 723 Harvey ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Walker.

6 DATE OF BIRTH (month, day, and year): Jan. 12. 1868

7 AGE — Years: 55 — Months: 3 — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Richard R. Walker.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Fallon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Lena Hauer

(Address) 723 Harvey St

15 Filed APR 20 1923 19.... ROBERT R. KRAUTEN, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18 .1923. to April 19 .1923.

that I last saw h in alive on April 19 .1923

and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured duodenal ulcer (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 4/18/23.

Was there an autopsy? Yes

What test confirmed diagnosis? P.S.S.

(Signed) Harold C. Pillsbury, M. D.

.19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: April 23 1923

20 UNDERTAKER: Perkins & Perkins — ADDRESS: 1759 Eager

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75015

CERTIFICATE OF DEATH.

70 74-001

D75015

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 32 N. Bentalou St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia R. Kelly

(a) Residence No. 32 N. Bentalou St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: James M. Kelly

6-DATE OF BIRTH (month, day and year): Mch 18, 1853

7-AGE: 70 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Moses Magness

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Lucy —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant) Rebecca Hill

(Address) 32 N. Bentalou St.

15- APR 20 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 18/23

17- I HEREBY CERTIFY, That I attended deceased from April 13, 1923 to April 18, 1923, that I last saw her alive on April 18, 1923, and that death occurred, on the date stated above, at 6.12 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage causing Aphasia & Right Hemiplegia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Senile Arterio sclerosis

(Duration) Several years

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Henry C. Friedrich M. D.

Apr 18 1923 (Address) 1203 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cemetery DATE OF BURIAL, April 21, 1923

20-UNDERTAKER, John O. Mitchell ADDRESS, 1201 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D75016

D75016

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 2008 Park ave - St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth L. Jones

(a) Residence No. 2008 Park ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single, Married~~ Widowed, or ~~Divorced~~, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert H. Jones

6-DATE OF BIRTH (month, day and year) Sept 28. 1839

7-AGE, 83 yrs. 6 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of Industry, business, or establishment in which employed (or employer)..... ~~Ohio~~

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Va
(State or Country),

PARENTS.

10-NAME OF FATHER, James Freeman

11-BIRTHPLACE OF FATHER (city or town)..... Va
(State or Country),

12-MAIDEN NAME OF MOTHER Charlotte Freeman

13-BIRTHPLACE OF MOTHER (city or town)..... Va
(State or Country),

14- (Informant) J. Henry Baker

(Address) 2008 Park ave

15- Filed..... 19.. ROBERT P. KRAUTER Registrar.

APR 20 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19. 1923

17- I HEREBY CERTIFY, That I attended deceased from April 13, 1923 to April 19, 1923 that I last saw h.~~e~~ alive on April 15, 1923 and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)..... yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration)..... yrs. mos. ~~one~~ ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Pearre, M. D.

4-19, 1923 (Address) 5 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL, April 21 1923

20-UNDERTAKER. John O Mitchell ADDRESS 221 N. Fayette St.

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—IE P. Co.—1000 Bks.

(Beall)

D75017

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D75017

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1617 Belt an ST 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Beall

(a) RESIDENCE. No. 1617 Belt an ST., WARD:
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Thomas

6 DATE OF BIRTH (month, day, and year) Dec 19 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. Va

PARENTS

10 NAME OF FATHER Alfred Beall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Helfenstay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Mrs. Sallie Beall (Address) 1617 Belt St.

15 Filed APR 20 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to April 18, 1923, that I last saw him alive on April 18, 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs mos. 5 Mos. days

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Suspected

(Signed) [illegible], M. D.

4-20-1923 (Address) 1 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	4/21/1923
20 UNDERTAKER	ADDRESS
C D Fanning & Son - 1460	Battery Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75018

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Beaver

(a) Residence No. 1009 Nursery Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1882

7-AGE.	If LESS than 1 day.
40 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9-BIRTHPLACE (city or town) St. Mary's Co., (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Gilbert Cotes

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country)

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) St. Mary's Co (State or Country) Maryland

14- (Informant) Municipal Hospital Record

(Address)

15- Filed APR 20 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 14 19 23 to April 18 19 23

that I last saw her alive on April 17 19 23

and that death occurred, on the date stated above, at 7:00 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

1

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Sputum

(Signed) J. A. Wickes M. D.

4-19-, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	April 20 1923
20-UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Ashland Av

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75019

D75019

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Thames ST., 2 nd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James P. Zborowski,

(a) RESIDENCE NO. 1802 Thames ST., 2 nd WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept., 6-1910.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	13	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School, old & Semanda's

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) MD.

PARENTS

10 NAME OF FATHER John Zborowski,

11 BIRTHPLACE OF FATHER (city or town) Posain,
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Dombrowski,

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mrs Mary Zborowski
(Address) 1802 Thames Street

15 Filed APR 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18- 1923.

17 I HEREBY CERTIFY, That I attended deceased from January, 1920, to April 18, 1923,
that I last saw him alive on April 15, 1923,
and that death occurred, on the date stated above, at 9.20 P- m.
The CAUSE OF DEATH* was as follows:

Sudden Heart Failure
due to Valvular Heart Lesion (duration) ... yrs. ... mos 9 ds.

CONTRIBUTORY
(Secondary) (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine, M. D.

April 19, 1923 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem., DATE OF BURIAL Apr 21- 1923.

20 UNDERTAKER M. F. Sadowski. ADDRESS 705 S. Ann

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatism

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75020

CERTIFICATE OF DEATH.

90 D75020

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 Guilford ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret B. Renshaw

(a) RESIDENCE. NO. 3012 Guilford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 4 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stone
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Penna.

PARENTS

10 NAME OF FATHER Wm B Renshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Margaret V. Goldey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Penna

14 Informant (Address) Thomas J. Bohannan 3012 Guilford Av

15 Filed APR 20 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 19 1923

17 I HEREBY CERTIFY, That I attended deceased from March 2nd, 1923, to April 19th, 1923, that I last saw h[illegible] alive on April 19th, 1923, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) Many yrs. — mon. — ds.

CONTRIBUTORY (Secondary) Mental delusions

(duration) — yrs. 6 mon. — ds.

18 Where was disease contracted if not at place of death? In Baltimore in early life

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? The usual examination

(Signed) for disease of the heart, M. D.
APR 19 1923 John J Bennington.
(Address) 1826 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL APR 21 1923 19

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE

MARGIN MUST BE KEPT CLEAR. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PENCIL should not be used. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75021

CERTIFICATE OF DEATH.

118-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Wehran

(a) Residence No. Preston & Bailey Sts St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6-DATE OF BIRTH (month, day and year) Oct. 6-1863

7-AGE. 60 yrs. 2 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Cook

(b) General nature of industry, business, or establishment in which employed (or employer). At the home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Frederick Co. Md.

PARENTS.

10-NAME OF FATHER. Charles Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Eliza Dutrow

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Sister Florence

(Address) Preston & Bailey

15- Filed APR 20 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 19 1923

17- I HEREBY CERTIFY, That I attended deceased from No record 19.. to ..19..

that I last saw h.. alive on April 19 1923

and that death occurred, on the date stated above, at 4-2 P. m.

The CAUSE OF DEATH* was as follows:

Inguinal Hernia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no - Date of refused

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D

April 19 23 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet — DATE OF BURIAL. Apr. 23 1923

20-UNDERTAKER. George L. Schwab — ADDRESS. 1101 Fulton Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75022

CERTIFICATE OF DEATH.

D75022

REGISTERED No. C 90

1-PLACE OF DEATH 1315 N. Gilmore St

CITY OF BALTIMORE: (No. 15 St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augustus Hirsch

(Residence in Baltimore: No. 1315 N. Gilmore St.; 65 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, July 1, 1831. (Month) (Day) (Year)

7-AGE, 91 yrs. 9 mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Adam Hirsch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Marie Neuman

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. L. Hirsch

(Address) 1315 N. Gilmore St

15- Robert P. Harrison,

Filed ....., 191.....

Registrar.

APR 20 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10th 1923, to April 18th 1923, that I saw him alive on April 18th 1923, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Tabes mesenteric Myocarditis

(Duration) yrs. 3 mos. 9 ds.

CONTRIBUTORY (Secondary) Asteno-Sclerosis, Senile

(Duration) 20 yrs. mos. ds.

(Signed) Chas. L. Hirsch M. D.

April 19th, 1923 (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, April 21, 1923

20-UNDERTAKER Wm. Cook - 501 E. North Ave — ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75023

CERTIFICATE OF DEATH.

90 D75023

Registered No.....

D75023

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel French

(a) Residence No. Preston & Caroline Sts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1846

7-AGE. 77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. John French

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER. Mary Sullivan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant). Sister Florence

(Address) Preston & Caroline

15- Robert E. Harrison, Registrar.

APR 20 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 19/23

17- I HEREBY CERTIFY, That I attended deceased from No record ....., 19....., to ....., 19.....

that I last saw h.. alive on April 17 19 23

and that death occurred, on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Wiedefeld M. D

, 19 (Address) 1138 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral April 23 19 23

DATE OF BURIAL.

20-UNDERTAKER. H. C. Wiedefeld

ADDRESS 914 Greenmount Ave

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ANSWER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75024

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of Poor 420 WARD)

2-FULL NAME John Mullikin

(a) RESIDENCE NO. Preston Valley Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Mullikin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Cullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sister Florence

(Address) Preston St.

15 APR 2 01923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 19.. to ..19.. ,19..

that I last saw him alive on April 19, 1923.

and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

19 . 1923 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 21 1923

20 UNDERTAKER H. C. Wiedefeld

ADDRESS 914 Greenmount Ave

D75025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75025

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. City Hospital St. Bayview Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and ward No. 18.)

2-FULL NAME Guy M. Hipple.
(Residence in Baltimore: No. City Hospital St.; yrs. mos. 1 ds.)
Havre de Grace Md

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE. White
5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. August (Month) 19. (Day) 1902 (Year)

7-AGE. 20 yrs. 9 mos. 0 ds. If LESS than 1 day, ... hrs. or ..... mins.

8-OCCUPATION
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE. (State or Country). Maryland.

PARENTS.
10-NAME OF FATHER. John M. Hipple
11-BIRTHPLACE OF FATHER. (State or Country). Pennsylvania
12-MAIDEN NAME OF MOTHER. Mary Johnson
13-BIRTHPLACE OF MOTHER. (State or Country) Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John M. Hipple
(Address) 612 S Washington Ave Havre de Grace Md

15. 192.
Robert P. Harrison, Registrar.
Burial Permit Clerk.

R 20 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

18-CAUSE OF DEATH was as follows:
Fractured Skull
Lacerated R. Lung
Laceration of Liver
(Duration) yrs. 4 mos. 3 hours
CONTRIBUTORY (Secondary) Automobile ran into ditch and overturned
(Duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.
(Coroner.)
Apr 20 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the state..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Havre de Grace Md.

19-PLACE OF BURIAL OR REMOVAL. Havre de Grace Md. DATE OF BURIAL. 4-20 1923

20-UNDERTAKER. E & S Hale ADDRESS 115 E West St

R. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Zepp)

D75026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75026

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2517 W Lombard St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Luther W. Zepp

(Residence in Baltimore: No. 2617 W Lombard St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Oct (Month) 27 (Day) 1877 (Year)

7-AGE. 45 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Motorman
(b) General nature of industry, business, or establishment in which employed (or employer): United RR Co

9-BIRTHPLACE, (State or Country): Westminster Md

PARENTS.

10-NAME OF FATHER: Joshua D. Zepp

11-BIRTHPLACE OF FATHER, (State or Country): Westminster Md

12-MAIDEN NAME OF MOTHER: Ida Sauerl

13-BIRTHPLACE OF MOTHER, (State or Country): Westminster Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E. Zepp

(Address) 2517 W Lombard

15- Robert F. Harrison, Registrar.

1923 Burial Permit Clerk.

R. 20 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:
Incised Wound of Throat
severing Ephem & Jugular
Vein & Hemorrhage
Suicide (Duration) ....yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Manslaughter Incapacity
(Duration) ....yrs. 3 mos. ....ds.

(Signed) James H. Fenton M. D.
(Coroner.)

April 18 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Krider Cem Westminster — DATE OF BURIAL: April 22 1923

20-UNDERTAKER: Jos Sueders & Son — ADDRESS: 2173 Pace

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D75027

REGISTERED NO. C

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 521 N. Eutaw St. St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. Deaver

(Residence in Baltimore: No. 128 W. Belvedere Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, June 25, 1874
(Month) (Day) (Year)

7-AGE, 48 yrs. 9 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Traveling
(b) General nature of industry, business, or establishment in which employed (or employer)..... Auditor

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. George R. Deaver

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Carrie C. Deaver

(Address) 128 W. Belvedere Ave

15-

Filed..... Robert P. Harrison, M.D.
Registrar.

APR 20 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hemsley M. D.
(Coroner.)

April 20, 1923 (Address) 180 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemy	April 23 1923
20-UNDERTAKER	ADDRESS
Jos Joerdens Son	217 S. Pearl

D75028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75028

CERTIFICATE OF DEATH.

8 100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1706 Lansing Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy M. Dernetz

(Residence in Baltimore: No. 1706 Lansing Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	single

6-DATE OF BIRTH. May 10, 1922, 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
yrs. 11 mos. 9 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of indnstry, bnsiness, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Joseph A. Dernetz

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Mary C. Buttner

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. A. Dernetz

(Address) 1706 Lansing Av e

15- Robert P. harrison, 192 Registrar.

PR 21 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia (Primary.)

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Collins M. D.
(Coroner.)

4/20/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemetery | DATE OF BURIAL. Apr 21 1923

20-UNDERTAKER, Henry Stock Son | ADDRESS 1301 E Fayett

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1003 N. Calvert St., 11 Ward)

Registered No. C. 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Clarence Shriver

(Residence in Baltimore: No. 1003 N. Calvert St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. Dec 22 1864
(Month) (Day) (Year)

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or mlg.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Gas Steamfitter
(b) General nature of ludustry, business, or establishment in which employed (or employer). Gas

9-BIRTHPLACE, (State or Country). Balto

PARENTS:
10-NAME OF FATHER. Geo. A Shriver
11-BIRTHPLACE OF FATHER. (State or Country). Md.
12-MAIDEN NAME OF MOTHER. Cl. Bengle
13-BIRTHPLACE OF MOTHER. (State or Country). Frederick

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M Shriver
(Address) Belair Md

15-
Filed 1923
Robert P. Harrison,
Registrar.
Burial Permit Clerk

R 21 1923

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr. 19 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide by Carbon monoxide poisoning while probably Suffering with temporary mental alteration
Short while (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) W J Riley (Coroner) M. D.
Apr 20 1923 (Address) 1659 Linden Ave

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death few minutes yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenmount Cem	April 21st 1923
20-UNDERTAKER.	ADDRESS
Henry H. Jenkins Sons	McCulloh & Orchard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75030

CERTIFICATE OF DEATH.

91-002 D75030

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Rochambeau Apts. ST., 4 WARD)

2-FULL NAME Lura G. Pruden

(a) RESIDENCE NO. Rochambeau Apts. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clarence D. Pruden

6 DATE OF BIRTH (month, day, and year) June 13" 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lisbon
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Henry G. Armstrong

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Vermont

12 MAIDEN NAME OF MOTHER Nancy Jane Rolf

13 BIRTHPLACE OF MOTHER (city or town) Lisbon
(State or country) N. Y.

14 Informant Mr. C. D. Pruden
(Address) Rochambeau Apts.

15 Filed ... 19 Robert T. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20" 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10" 1923 to April 20" 1923
that I last saw h[er] alive on April 20" 1923
and that death occurred, on the date stated above, at 11.20A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wyman Whitney Perkins, M. D.

4/20 1923 (Address) Rochambeau Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Apr 23" 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St

PLEASE PRINT—THIS IS A PERMANENT RECORD. ENTRIES should be made with INDELIBLE INK—WRITE PLAINLY, WITH UNFADING INK—(Name of deceased in full should be given in Item 2. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 21 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75031

CERTIFICATE OF DEATH.

D75031

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N. Stricker St. ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta A. Hildebrandt

(a) RESIDENCE NO. 516 N. Stricker St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 22"1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Hildebrandt

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Achsah Marriott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

14 Informant Frank M. Hildebrandt (Address) 516 N. Stricker St.

15 APR 2 1923 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to April 19, 1923

that I last saw her alive on April 18, 1923

and that death occurred, on the date stated above, at 4.40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon N. London, M. D.

4/21, 1923 Address 750 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Apr. 21 1923
20 UNDERTAKER Adolph B. Cook	ADDRESS 1003 N. Calvert St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75032

CERTIFICATE OF DEATH.

90 D75032

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3613 Fernwood ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa C. Young

(a) RESIDENCE NO. 3613 Fernwood ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Lind

6 DATE OF BIRTH (month, day, and year) May 17. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Derker

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Keyser

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Her Home
(Address) 3613 Fernwood Ave

15 Robert F. Harrison,
Filed ..... 19 ..... Registrar
Burial Permit Clerk

APR 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 17 .1923. to April 18 .1923.
that I last saw her alive on April 18 .1923.
and that death occurred, on the date stated above, at 5 a.m.
The CAUSE OF DEATH* was as follows:
Acute Indigestion

(duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary) Valvular Heart trouble

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Collenberg M. D.

Apr 24 1923 (Address) 1810 N Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Apr 22, 23
20 UNDERTAKER John Reisch	ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 1501 D75033

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 608 School St. St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Howard Hall

(Residence in Baltimore: No. 608 School St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	colored	widower

6-DATE OF BIRTH, about ..... (Month) ..... (Day) 1867 (Year)

7-AGE. 56 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Porter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Celia Magruder

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evelyn Walker

(Address) 742 N. Franklin

15- Filed ....., 191.... Robert P. Harrison, Registrar.

APR 21 1923

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April (Month) 19 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) hypertrophy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

April 17 1923 (Address) 1502 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Comp. Lib. Rd	4/21, 1923
20-UNDERTAKER	ADDRESS
Samuel Mousley	1718 Madison St.

D75034

HEALTH DEPARTMENT—CITY OF BALTIMORE D75034

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 704 Gengt St., St.: 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James D. Addison

(Residence in Baltimore: No. 704 Gengt St. St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... about ....., 1857
(Month) (Day) (Year)

7-AGE, ... 67 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Latha
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), [illegible]

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Burton

(Address) 7 E 102 Druid Lane

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

APR 21 1923

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Bronco Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... no history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... D. T. Hennessy M. D.
(Coroner.)

April 19, 1923 (Address) 3 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, April 21, 1923

20-UNDERTAKER, Samuel T. Hensley

ADDRESS 508 N Eutaw St

Spec.—1-10-21—M&T—1500 Blks.

D75035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75035

CERTIFICATE OF DEATH.

X 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Jones Grady

(a) RESIDENCE NO. St Vincents' Inf. Asy ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 8 mos. — ds. How long in U. S., if of foreign birth? — yrs. 8 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write~~ the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE Years 1 Months 6 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Berkenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frances Grady.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant St Vincent Infant Asylum

(Address) 801 Bunsen Ave

Filed 4 21 1923 .19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to April 20, 1923.

that I last saw h[illegible] alive on April 20 - 1923,

and that death occurred, on the date stated above, at 1 [illegible]

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward H. Kirkowski, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 4/21 1923.

20 UNDERTAKER Martin Grady Sons — ADDRESS 1827 W North

20—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75036

CERTIFICATE OF DEATH.

X 141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella D. Ross.

(a) RESIDENCE NO. Lud Brook Park Md. WARD Ludbrook Park Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Thomas R Ross

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Deagey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Curran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thos B Ross

(Address) Lud Brook Park

15 Filed Apr 21 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1923 to April 20, 1923.

that I last saw her alive on April 20, 1923

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prostatectomy (Operation)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of April 20-23

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) R. G. Miller, M. D.

, 19 (Address) 18 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Charles Pikesville	4/23 1923
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons.	1827 W North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item and figure should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Severidt)

D75037 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D75037

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE PHYSICIAN'S should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryw Hosp ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas H Severidt

(a) RESIDENCE NO. 439 N- Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not known.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Fredk Severidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mckenzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Holton (Address) 2677 Loudon Ave.

15 Received APR 21 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to April 20, 1923, that I last saw him alive on April 20, 1923 and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary T B.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam. Sputa.

(Signed) J C Graves, M. D.

, 1923 (Address) Marow Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 23 1923

20 UNDERTAKER ADDRESS

F B Hepbert 2755 Frdk Ave

Spec.—1-10-21—M&T—1500 Bks.

D75038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D75038

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2545 W. Lombard ST., 20 WARD)

2-FULL NAME Myrtle E. Sorenson

(a) RESIDENCE NO. 2545 W. Lombard ST., 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 13/08

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	14	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Sorenson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret M. Krauchaar

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. E. Sorenson
(Address) 2545 W. Lombard St

15 Filed APR 21 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1922, to apr 20, 1923,

that I last saw her alive on apr 19, 1923,

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

general tuberculosis
starting in lungs.

chronic
(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Krantz M. D.

Apr 20, 1923 (Address) 1002 N. Ranvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 24
London Park Cemetery	April 1923
20 UNDERTAKER	ADDRESS
H. B. Hopkins Wm Fred'k Sons	

Spec. 1-10-21 M&T 1500 Blks.

D75039

HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ D75039

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Alexandrafski

CITY OF BALTIMORE: (No. 838 Hollins ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Caroline Robinson

(a) RESIDENCE NO. 838 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~

4 COLOR OR RACE White

5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~ Widow

5a If married, widowed, ~~or divorced~~ (or) WIFE of ~~HUSBAND of~~ Elias P. Robinson

6 DATE OF BIRTH (month, day, and year) 1853-12-2

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	69	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER David L. Bartlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Sarah Abbe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant E. Winans Robinson

(Address) Moncton - N. J.

15 Filed APR 2 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APRIL 20th 1923

17

I HEREBY CERTIFY, That I attended deceased from APRIL 10th, 1923, to April 20th, 1923,

that I last saw her alive on APRIL 20th, 1923,

and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic NEPHRITIS

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) CARCINOMA (HAND & Glands axillae)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 1923

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Thomas L. Shedrer, M. D.

Ap 21st 1923 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 4-23 1923

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS McCulloh Orchard

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75040 CERTIFICATE OF DEATH. 44 D75040

1-PLACE OF DEATH Hebrew Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 940 E Broadway ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Wintemitz

(a) RESIDENCE NO. 940 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Wintemitz

6 DATE OF BIRTH (month, day, and year) ? 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Hardware

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Hiram Wintemitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jasmine Hulda

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Carrie Wintemitz (Address) 940 N Broadway

15 Filed Robert P. Harrison Registrar

R 21 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to April 21, 1923, that I last saw h in alive on ..21, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(Hemorrhage)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? laboratory tests

(Signed) Isidor L. Filby, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew	April 23 1923

20 UNDERTAKER Jahrens & Colvill Mad ave ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful in filling out this certificate. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE, CAUSE OF DEATH and PLACE OF BURIAL must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75041

CERTIFICATE OF DEATH.

161-00 D75041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gregory Sheffield.

(a) RESIDENCE NO. 19 Retreat St. City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Sheffield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed ..., 19... Robert P. Hartman Registrar

2 1 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1923. to April 20. 1923.

that I last saw him alive on April 20. 1923.

and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary) Primary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. A. Mead, M. D.

..., 19... (Address) JOHNS HOPKINS HOSPITAL.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 4/24 1923

20 UNDERTAKER Martin-Lukey Co 1827 W North

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75042

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C 90

City of BALTIMORE: (No. 307 W Balto st St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Simon C. Adler

(Residence in Baltimore: No. Riviera apts Linden av & Eutaw pl St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. June (Month) 22 (Day) 1867 (Year)

7-AGE. 55 yrs. 9 mos. 29 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Chas Adler

11-BIRTHPLACE OF FATHER. (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Caroline Frank

13-BIRTHPLACE OF MOTHER. (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Lovenheimer

(Address) Rivera apts

15- Robert F. Harrison, Registrar.

APR 21 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) a few minutes

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H. K. Bonnell M. D. (Coroner.)

4-21 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Balto Hebrew Cem	4/22/1923
20-UNDERTAKER. David Sondheim	ADDRESS 115 20 W Mt Royal Ave.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS: state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D75043

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D75043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Alhambra Apts ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline S. Straus

(a) RESIDENCE NO. Alhambra Apts. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William L Straus

6 DATE OF BIRTH (month, day, and year) Feby 12, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Joel Gutman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Hayton

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant

(Address) Alhambra Apts.

15 Robert P. Harrison

. 19 Registrar

R 2 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17

I HEREBY CERTIFY, That I attended deceased from 2 April, 1923, to 21 April, 1923, that I last saw h-r alive on 21 April, 1923, and that death occurred, on the date stated above, at 8.15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 9 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical History & Laboratory

(Signed) Thomas W Ryan, M. D.

, 19 (Address) 749 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 4/23/ 1923.

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

B. WRITE plainly and carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75044

113

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 134 N Calhoun ST. 15 WARD)

2-FULL NAME Dorothy Anthony

(a) RESIDENCE NO. 134 N Calhoun ST. WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 27 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Cecil Md

PARENTS

10 NAME OF FATHER John Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maggie Messick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie Anthony

(Address) 134 N Calhoun St

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

R 2 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 18, 1923, to Apr 19, 1923, that I last saw her alive on Apr 19, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr William Frey, M. D.

Apr 20, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL April 21 1923

20 UNDERTAKER James F. Dennis ADDRESS 203 Eastern.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

Fulton - Lombard
Cox

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75045

CERTIFICATE OF DEATH.

31 D75045

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2223 Christian Street (WARD) 20

2-FULL NAME Lena Bach

(a) RESIDENCE NO. 2223 Christian Street WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Henry D. Bach

6 DATE OF BIRTH (month, day, and year) May 29-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER August Berding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Knopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hannah High

(Address) 1223 Christian St

15 APR 21 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to April 20, 1923, that I last saw her alive on April 20, 1923, and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

months

(duration) yrs. moa ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A Cox, M. D.

(Address) 547 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Park — DATE OF BURIAL April 23 1923

20 UNDERTAKER W. J. Cook — ADDRESS 502 E North

IMPORTANT.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75046 10 D75046

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (N) Sydenham Hospital ST., WARD)

2-FULL NAME Angelo Maranto.

(a) RESIDENCE NO. 1123 N. Montford ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Sam Maranto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Grieco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna Maranto
(Address) 1123 N. Montford ave

15 Filed APR 21 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1923, to April 21, 1923, that I last saw h[illegible]ive on April 20, 1923, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B Macpherson M. D.

4/21/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Apr 22, 1923

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

I. B. Write plainly and fill all blanks carefully supplied. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D75047

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Druid Park ave ST., 11 WARD)

2-FULL NAME Garrett Granville Joseph Williams

(a) RESIDENCE No. 1009 Druid Park ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year): Apr 10 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer): infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Md

PARENTS

10 NAME OF FATHER Garrett D Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Marthonsville Hard Co

12 MAIDEN NAME OF MOTHER Marthas gosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sykesville Hard Co

14 Informant: Marthas gosnell

(Address) 1009 Druid Park ave

15 Filed APR 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to April 21, 1923,

that I last saw h— alive on April 21, 1923;

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Suspected Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

4/21, 1923 (Address) 1230 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marrettville Hard Co

DATE OF BURIAL: April 22, 1923

20 UNDERTAKER: John F Owens

ADDRESS: 538 Walbert

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

75048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75048

CERTIFICATE OF DEATH.

118-002 D75048

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Jeanette Carey

(Residence in Baltimore: No. 815 N. Bond St.; yrs., 3 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	married

6-DATE OF BIRTH, unknown (Month) 1 (Day) (Year)

7-AGE. 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Hampton Va.

PARENTS.

10-NAME OF FATHER: Walter Thomas

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Sallie Brooks

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TREE TO THE BEST OF MY KNOWLEDGE.

(Informant) W.B. Brooks

(Address) Hampton Va.

15- APR 22 1923 Filed 192.

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20/23 (Month) (Day) (Year) 192.....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis due to intestinal obstruction caused by post operative adhesions (AUTopsy at Hopkins hospital)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. W. Collins M. D. (Coroner)

4/21/23 192. (Address) 508 E. North ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Hampton Va. DATE OF BURIAL. April 21 19.23

20-UNDERTAKER. Robert V Williams ADDRESS 1518 Madison St

Spec. 1-10-21—M&T—1500 Blks.

D75049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75049

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wallis Ave. (Cheswold) ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Gemundt

(a) RESIDENCE NO. Wallis Ave. (Cheswold ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L? Gemundt

6 DATE OF BIRTH (month, day, and year) Aug. 19th. 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Dover (State or country) Delaware

10 NAME OF FATHER Mr. Bratton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Bessie M. White (Address) Wallis Ave. (Cheswold)

15 Filed APR 22 1923 ROBERT R. KRAUTER, Burial Permit Registrar Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20th 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1922, to April 20, 1923, that I last saw her alive on April 19, 1923; and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis - Arterio-Sclerosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis - Arteris Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E W Bishop, M. D.

, 19 (Address) 222 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 22 1923
UNDERTAKER Joseph D. Cook	ADDRESS 1003 N. Calvert St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75050

CERTIFICATE OF DEATH.

90 ✓ D75050

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1627 Orleans ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Briggs

(a) RESIDENCE. NO. 1627 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonathan

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65 yrs.	✓		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 10 0

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Geo. Thompson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hathaway

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Bernard Briggs
(Address) 910 N Bond St.

15 FILED APR 22 1923 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 1923, to Apr 19, 1923, that I last saw h. alive on April 19, 19..., and that death occurred, on the date stated above, at 4 40 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

4/20 1923 (Address) 1612 E monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery Apr	22 1923
20 UNDERTAKER	ADDRESS
Milton Davis	3142 Edm

Milton Davis

Information should be carefully supplied. Age, color and condition must be properly classified. Exact statement of OCCUPATION should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75051

CERTIFICATE OF DEATH.

49

D75051

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2007 Druid Hill Ave St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob A. Henderson

(Residence in Baltimore: No. 2007 Druid Hill Ave St.; 50 yrs. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day) 1873 (Year)

7-AGE, 50 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Gladis Henderson

(Address) 2007 Druid Hill Ave.

15- Filed APR 22 1923, 191.....

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 20, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14 1922, to Apr. 20 1923, that I saw him alive on Apr. 20 1923, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 5 mos.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 mos.

(Signed) [illegible] M. D.

Apr 21, 1923 (Address) 515 Hoffman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, April 22 1923

20-UNDERTAKER George H. Holland — ADDRESS 1631 Druid Hill Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75052

CERTIFICATE OF DEATH.

5 129 D75052

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Aisquith ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susiana Ida H. Jones

(Residence in Baltimore: No. 207 Aisquith St.; 5 yrs., ... mos. ..... ds.)

May be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Exact date Unknown, ... (Month) ..... (Day) 1 (Year)

7-AGE, 70 yrs. (Approx) ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Do

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elliott

(Address) 172 Ashland Ave.

15- Filed APR 22 1923, 191..... ROBERT R. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 19 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1922, to April 19 1923, that I saw h[illegible] alive on April 18 1923, and that death occurred, on the date stated above, at 4 AM m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia Resp.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Thomas M. D.

4/19..., 1923 (Address) 1424 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Ashury Cemetery — DATE OF BURIAL, April 22, 1923

20-UNDERTAKER Mrs. R. C. Elliott — ADDRESS 172 Ashland Ave

Spec.—1-10-21—M&T—1500 Blks.

Nudel

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75053 D75053

CERTIFICATE OF DEATH. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 N. Monroe ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fannie Nudel

(a) RESIDENCE No. 1641 N. Monroe ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE Wht

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Israel Nudel

6 DATE OF BIRTH (month, day, and year) Dec. 16/1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	61	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant I. Nudel

(Address) 1641 N Monroe St

15 Filed APR 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1923

17

I HEREBY CERTIFY, That I attended deceased from ~~Apr~~ July, 1922, to Apr. 20, 1923,

that I last saw ~~her~~ alive on Apr. 20, 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach & Intestines (Carcinoma) began in Cardiac portion of Stomach.

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Nursing & Weakness

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Johns Hopkins Hosp. Diagnosed Clinically

(Signed) [illegible] M. D.

4/21, 1923 (Address) 605 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL 4/22 1923

20 UNDERTAKER S. Levinson & Bro

ADDRESS 127 E Belton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75054

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D75054

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2723 Raynor ave ST. 16 WARD)

2-FULL NAME Pascal L. Brandenburg

(a) RESIDENCE No. 2723 Raynor ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? 24 yrs. 3 mos. 10 ds.

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 9, 1899

7 AGE — Years: 24 Months: 3 Days: 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Upholstering

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Harvey L. Brandenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Maude Hung

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Mrs L. Fleshear (Address) 2723 Raynor ave

15 Filed APR 22 1923 ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/19/1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 18, 1923, to Apr 19, 1923, that I last saw him alive on Apr 19, 1923, and that death occurred, on the date stated above, at 1210 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) yr. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Oedema of Lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) John A. Whitehead M. D.

Apr 20 1923 (Address) 1219 Eaplan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: 4/23, 1923

20 UNDERTAKER: L. Levinson & Bro

ADDRESS 1127 E Balto st

Spec.—1-10-21—M&T—1500 Bks.

Fishbaun ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75055

CERTIFICATE OF DEATH.

160 D75055

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3600 Cedar ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Fishbaun

(a) RESIDENCE NO. 3600 Cedar ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19, 1923

7 AGE Years Months Days 2 If LESS than 1 day hrs. 11 or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Hyman Fishbaun

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Ida Yaniger

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant (Address) Hyman Fishbaun 3600 Cedar ave

15 APR 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1923. to April 21, 1923.

that I last saw h[illegible] alive on April 21, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Sinusitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/24 1923 (Address) 1575 N Bentalou

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Cem DATE OF BURIAL April 22 23

20 UNDERTAKER M. J. Jenkinson ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

that it may be properly classified. Exact statement of OCCUPA-

ns on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75056

CERTIFICATE OF DEATH.

9 D75056

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 E Broadway ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Anthony Miller

(a) RESIDENCE NO. 2202 E Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John L. Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Marie L. Frankenfield

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant John L. Miller
(Address) 2202 E. Broadway

15 FILED APR 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 11, 1923, to Apr 21, 1923, that I last saw him alive on Apr 21, 1923, and that death occurred, on the date stated above, at 11 20 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No Physical Signs

What test confirmed diagnosis?

(Signed) H. L. Kantner M. D.

19 20 (Address) 201 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemt	Apr 22- 1923
20 UNDERTAKER	ADDRESS
J. Strambler	1237 E Fay

mation should be carefully supplied. AGE should be stated EXACTLY. FIGURES should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75057

CERTIFICATE OF DEATH.

101-001 D75057

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 Jefferson 6 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Deaz

(Residence in Baltimore: No. 1431 Jefferson St.; 32 yrs., — mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Col	Married

6-DATE OF BIRTH, ... July (Month) 4 (Day), 1874 (Year)

7-AGE, 48 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, John Holland

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Hutchison

13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H Dean

(Address) 1431 Jefferson St

15- APR 22 1923 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 13 1923, to Apr 20 1923, that I saw h[er] alive on Apr 20 1923, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ...yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

(Signed) F. C. Lamb M. D.

Apr 21, 1923 (Address) 1313 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	April 24, 1923.
20-UNDERTAKER Edward Bryon	ADDRESS 1631 Orleans st

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75058 | 129 D75058

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 Wilkins Ave St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Zinkand.

(a) RESIDENCE NO. 1737 Wilkins Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Pauline Zinkand.

6 DATE OF BIRTH (month, day, and year) Sept 24 185[illegible]

7 AGE: Years 71; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Andrew Zinkand

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Pauline E. Zinkand.

(Address) 1737 Wilkins Ave

15 ROBERT R. KRAUTER, Registrar

Filed APR 22 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to Apr. 20, 1923,

that I last saw h[illegible] alive on Apr 19, 1923,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Tuberculosis cryptorchismus with adenocarcinoma.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? 0 Date of 0

Was there an autopsy? 0

What test confirmed diagnosis? 0

(Signed) J. O'Neill, M. D.

4/24-1923 (Address) 804 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 4-24 1923

20 UNDERTAKER: E & B Hasle 115

ADDRESS: E West St

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Shores.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75059

CERTIFICATE OF DEATH.

161-002 D75059

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 n Kenwood St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wanda Shores

(Residence in Baltimore: No. 30 n Kenwood St.; ..... yrs., ... mos. Life ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, April 18, 1923 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Fletcher A Shores

11-BIRTHPLACE OF FATHER (State or Country). Somerset Co Md

12-MAIDEN NAME OF MOTHER Blanche Jones

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Fletcher A Shores

(Address). 30 N Kenwood

15-

Filed APR 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April 21, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1923, to Apr 21 1923, that I saw h.. alive on Apr 21 1923 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pt Lapsed time from

Convulsions 3 hr

(Duration) ..... yrs. ..... mos. 3 hr

CONTRIBUTORY (Secondary) Central Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Ralph Estrop M. D.

4/22, 1923 (Address) 26 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cem — DATE OF BURIAL. Apl 23 1923

20-UNDERTAKER John Ullrich — ADDRESS 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75060

CERTIFICATE OF DEATH.

118-002 D75060

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph's Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie D Greenfield

(a) RESIDENCE NO. Greenfield & White Ave. Hamilton, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip C. Greenfield

6 DATE OF BIRTH (month, day, and year) Nov. 19th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	78	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jabez Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Caroline Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Harvey Greenfield

(Address) Greenfield Ave Hamilton

15 APR 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18 1923 to April 21 1923

that I last saw her alive on April 21 1923

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ac. Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 4/20/23

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) S W Kinney, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional advice.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	April 23
20 UNDERTAKER	ADDRESS
Fred'k Lassahn & Son	Fulton

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75061

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75061

CERTIFICATE OF DEATH. — X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 N. Calhoun ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara C. Mason

(a) RESIDENCE No. 1503 N. Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill all items. Use ditto marks only when they will not be misunderstood. Do not use abbreviations or technical terms. Define all diagnostic terms. Write plainly with pen and ink. Do not use pencil. Make no erasures. Consult reverse side for additional instructions. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. [illegible] 1837 / 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
86				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Bizar Lankford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sandy Houston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant's (Address) Robt L Lankford Roslyn Md

15 Filed APR 22 1923 ROBERT R. KRAUTER, Register. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1923

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1923, to April 18, 1923.

that I last saw her alive on April 18, 1923.

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Bright's Disease & Complication of Diseases (duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Bright Disease & Complication Diseases (duration) yrs. 10 mos. 12 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. W. Hennard M. D.

4-21, 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Baptist Woodlawn Md

DATE OF BURIAL 4/22 1923

20 UNDERTAKER Samuel T. Hensley

ADDRESS 578 Biddle

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75062

CERTIFICATE OF DEATH.

238 D75062

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 11 WARD)

2-FULL NAME Robert Williams

(a) RESIDENCE NO. 1024 N. Eutaw ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline J. Williams

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Dr. Irving J. Spear

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va. Accomack

12 MAIDEN NAME OF MOTHER Sallie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant University Records (Address)

15 FILED APR 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to April 20, 1923, that I last saw him alive on April 20, 1923, and that death occurred, on the date stated above, at 9-15 P m.

The CAUSE OF DEATH* was as follows:

Aneurism Thoracic Aorta

Metastasis (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Terminal Bronchs-Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of 4/16/23

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray & Autopsy

(Signed) Wm. J. Sellers M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL 4/23/23

20 UNDERTAKER Samuel T. Devereux ADDRESS 578 N. Eutaw

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—1-10-21—M&T—1500 Blks.

Norwitz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75063

CERTIFICATE OF DEATH.

90 D75063

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Incurables Home

CITY OF BALTIMORE: (No. 2100 E. Balto. ST., 15 WARD)

2-FULL NAME Ida Norwitz

(a) RESIDENCE NO. 3614 Park Heights Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 20 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ——— 1833

7 AGE — Years: 90 — Months: — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Isaac Kaudner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Fact Lewis 1399 Bals. St.

15 FILED APR 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1923, to April 21, 1923, that I last saw her alive on April 21, 1923, and that death occurred, on the date stated above, at 3p m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. J. Baysden M. D.

4-22, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: April 22 1923

20 UNDERTAKER: Fact Lewis — ADDRESS: 1399 E. Balto

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75064

CERTIFICATE OF DEATH.

44 D75064

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 Goodwood Road Hamilton WARD 07)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Blome

(a) RESIDENCE No. 214 Goodwood Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., If of foreign birth? 51 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Henry Blome

6 DATE OF BIRTH (month, day, and year) Nov 28 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	69	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Raschen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Sontanen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry B. Vogel

(Address) 214 Goodwood Road

15 Filed APR 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 16, 19 23, to Apr 21, 19 23, that I last saw h alive on April 20, 19 23, and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Gall-stone

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) 1 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred Fellner M. D.

19 (Address) 2724 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Baltimore

DATE OF BURIAL APR 24 1923

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE

mation should be carefully supplied. Age CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Lasher ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75065 | 161-001 | D75065

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2022 Jefferson ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Lasher

(a) RESIDENCE. No 2022 Jefferson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Lasher Jr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Eva Pintel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant John Lasher Jr
(Address) 2022 Jefferson St

15 Filed APR 22 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1923, to April 21, 1923, that I last saw h[illegible] alive on April 21, 1923, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth at 8th month, And Cyanosis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Diagnosis

(Signed) Adolph C. Eisenberg, M. D.

April 21, 1923 Address 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL Apr 23 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK. All blanks should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully classified. AGE and OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75066

CERTIFICATE OF DEATH.

21 D75066

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 810 N. 37th St. (ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond C. Garrison

(a) RESIDENCE NO. 810 N. 37th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Raymond M. Garrison

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillie M. Art

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Raymond M. Garrison
(Address) 810 N. 37th St.

15 APR 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1923, to April 20 1923, that I last saw him alive on April 20 1923, and that death occurred, on the date stated above, at 8.25 P. m.

The CAUSE OF DEATH* was as follows:

Gen. Septicemia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Infected Gland - Throat - Erysipelas (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of April 9 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) Wm F. Kelly, M. D.

4/22 1923 (Address) 2705 Talbot Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	April 23, 23
UNDERTAKER	ADDRESS
Horace R. Burgee	363 Falls Rd

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75067

CERTIFICATE OF DEATH.

101-001

D75067

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2909 Dona Terrace ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave A. Zipp

(a) RESIDENCE. No. 2909 Dona Terrace ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Annie Zipp

6 DATE OF BIRTH (month, day, and year) Jan 30th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip Zipp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jane Hoen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Zipp

(Address) 2704 Dona Terrace

15 FILED APR 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1923

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 21, 1923

that I last saw him alive on April 21, 1923

and that death occurred on the date stated above, at 4 A M

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W Donaldson, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 25th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

D75068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75068

CERTIFICATE OF DEATH.

X/85

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Bay View Hospital (Street) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul J. H. Irvin

(Residence in Baltimore: No.....St.; yrs.....mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. June 21st (Month) (Day) 1876 (Year)

7-AGE. 46 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Washington, Ga.

PARENTS.

10-NAME OF FATHER. Benjamin Irvin

11-BIRTHPLACE OF FATHER. (State or Country). Washington, Ga

12-MAIDEN NAME OF MOTHER. Martha S. Hill

13-BIRTHPLACE OF MOTHER. (State or Country) Washington, Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bay View Hospital

(Address) Bexo, Md

15- Filed APR 22 1923 BY ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21st (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage, Brain — Fractured — accidental Skull

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Fall on Cement Floor Fractured Skull

(Duration) ....yrs....mos....ds.

(Signed) Thos. P. Peterson M. D.
(Coroner)

Apr 22 1923 (Address) Curtis Bay,

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos. 19 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Richmond Hill L. I.

19-PLACE OF BURIAL OR REMOVAL. Brooklyn N.Y. DATE OF BURIAL. 4/24/23 19....

20-UNDERTAKER. W. J. Sulmer & Sons ADDRESS Penna Ave North Ave

N. B.—Every item of information above to be properly classified. Exact statement of OCCUPATION may be necessary so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75069

D75069

CERTIFICATE OF DEATH. 1 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Chelsea Terrace (STREET) 12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis H. Lerin

(a) RESIDENCE No. 2104 Chelsea Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Lerin

6 DATE OF BIRTH (month, day, and year): Jany. 13 1866

7 AGE: Years 57 Months 3 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Exec. Director of Fed.

(b) General nature of industry, business, or establishment in which employed (or employer): of Asso. Jewish Charities

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Charleston, S.C.

PARENTS

10 NAME OF FATHER: Harris Lerin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Dora Levine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mrs. Bertha Lerin

(Address): 2104 Chelsea Terrace

15 FILED APR 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21st, 1912, to April 21st, 1923, that I last saw h living on April 21st, 1923, and that death occurred, on the date stated above, at 1.15 PM.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. 9 mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? all clinical facts

(Signed) Eugene Shapiro, M. D.

, 19 (Address) 2004 Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Heb. Friendship Cem. DATE OF BURIAL: 4/23/1923

20 UNDERTAKER: David Londheim ADDRESS 114-16 W. Mt. Royal Ave.

AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

8spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75070

CERTIFICATE OF DEATH.

31 D75070

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 N. Dallas St., 8 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. E. Haff

(a) RESIDENCE NO. 1818 N. Dallas ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Earles

6 DATE OF BIRTH (month, day, and year) May 20 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	35	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Finisher

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer W. H. Edelmuth Co

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Haff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Kate Cowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs Ella Haff (Address) 818 N Dallas

15 APR 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1921, to Apr. 20, 1923, that I last saw h[illegible] alive on Apr. 8, 1923, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

about (duration) 2½ yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Exam of Sputum and X Ray and Clinical Evidence

(Signed) [illegible] M. D.

Apr 21, 1923 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Apr. 24 1923

20 UNDERTAKER	ADDRESS
Wm Cook	1002 E. Monument

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75071 X123 D75071

1. PLACE OF DEATH — CITY OF BALTIMORE; (No. Woman's Hospital ST., 14 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Edna Viola Dixon

(a) RESIDENCE NO. Bel Air Md. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winfield W. Dixon.

6 DATE OF BIRTH (month, day, and year) Feb 9, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2	12.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Faulston (State or country) Maryland

PARENTS
10 NAME OF FATHER John W. Walker
11 BIRTHPLACE OF FATHER (city or town) Faulston (State or country) Md.
12 MAIDEN NAME OF MOTHER Lucy B. Divins.
13 BIRTHPLACE OF MOTHER (city or town) Faulston (State or country) Md.

14 Informant Winfield W Dixon (Address) Bel Air Md.

15 APR 22 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to April 21, 1923, that I last saw h[illegible] alive on April 21, 1923, and that death occurred, on the date stated above, at 6:55 P. m.

The CAUSE OF DEATH* was as follows:
Toxic myocarditis
Terminal bronchopneumonia
(duration) yrs. mos 3 ds.
CONTRIBUTORY (Secondary) Cholelithiasis & acute Lepatitis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of April 8, 1923
Removal of Gall Stones
Was there an autopsy? No
What test confirmed diagnosis? Typical Examination
(Signed) Herman E Sammenbaum M. D.
, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fallston Md — DATE OF BURIAL April 24 1923

20 UNDERTAKER William Cook — ADDRESS 526 E Baltimore

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D75072

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 16 West 21st St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Charlotte D Wolf

(a) Residence No... 16 West 21 St., Ward...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 1834

7-AGE, 88 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), York Pa

PARENTS.

10-NAME OF FATHER, Daniel Wolf

11-BIRTHPLACE OF FATHER (city or town) (State or Country), York Pa

12-MAIDEN NAME OF MOTHER, Sarah E Stine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), York Pa

14- (Informant) Mr Frederick A Stillinger (Address) 12 West 21 St Balto

15- FILED APR 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

Balto 2409 Md Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 21/23

17- I HEREBY CERTIFY, That I attended deceased from April 11th, 1923 to April 21st, 1923, that I last saw h. alive on April 20th, 1923 and that death occurred, on the date stated above, at 6 29 m.

The CAUSE OF DEATH* was as follows:

Broncle-pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emmyl R Cronin, M. D.

, 19 (Address) 2409 Md Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
York Pa	April 24 1923
UNDERTAKER,	ADDRESS
William Cook	502 E Balto

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D75073

CERTIFICATE OF DEATH.

D75073

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1708 Ensquith St

CITY OF BALTIMORE: (No. 1708 Ensquith ST., 9 WARD)

2-FULL NAME Susan Ann Williams

(a) RESIDENCE NO. 1708 Ensquith ST., 9 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of: Robert A Williams

6 DATE OF BIRTH (month, day, and year): Nov. 9 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Joseph Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Maria Dieterich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant: Robert Williams (Son) (Address) 1708 Ensquith St

15 Filed APR 22 1923 ROBERT K. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1918, to April 20, 1923, that I last saw her alive on April 20, 1923 and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cirrhosis of Kidneys

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) W. O'Donnell M. D.

April 20, 1923 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: April 23 1923

20 UNDERTAKER: John Tedd — ADDRESS: 1200 W Lombard St

Information should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Avoid abbreviations. See instructions on back of certificates. INFORMATION is very important. See instructions on back

Spec.—12-23-21—E.B.R.S.—400 Blks.

D75074

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D75074

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2327-W-North St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Arthur Otto Brickman

(a) Residence No. 2327-W-North Av St., 15 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 58 yrs. 8 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Annie E. Brickman

6-DATE OF BIRTH (month, day and year) August-14-1864

7-AGE. 58 yrs. 8 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Druggist

(b) General nature of industry, business, or establishment in which employed (or employer). Drugs

(c) Name of employer. Self

9-BIRTHPLACE (city or town) (State or Country). Allentown Penna

PARENTS.

10-NAME OF FATHER. Arthur A. Brickman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Nottown Germany

12-MAIDEN NAME OF MOTHER. Susan Spangler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown Germany

11- (Informant) Arthur O. Brickman Jr. (Son)

(Address) 2327 W. North Ave

APR 23 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 22-23

17- I HEREBY CERTIFY, That I attended deceased from April 11 1923, to April 22 1923, that I last saw h.. alive on April 21 1923, and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ... yrs. ... mos. 11 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G W Billups M. D

April 27-1923 (Address) 2224 W. Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cemetery

DATE OF BURIAL. Apr 24 1923

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Should be carefully filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spcc. 6-9-19—H. P. Co.—1000 Blks.

D75075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D75075

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST. 38th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Calnan

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28th WARD Schuylkill Haven Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 55 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-5-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	0	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cressona Pa.

PARENTS

10 NAME OF FATHER Michael Calnan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cork Ireland.

12 MAIDEN NAME OF MOTHER Rosalie Calnan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cork Ireland.

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md.

15 Filed APR 23 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22nd 1923

17

I HEREBY CERTIFY, That I attended deceased from June 1st, 1912, to Apr 22nd, 1923, that I last saw her alive on Apr 21st, 1923 and that death occurred, on the date stated above, at 7.40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chronic Psychosis - abt (duration) 11 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Apr 22nd 1923, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schuylkill Haven Pa. DATE OF BURIAL: Apr 23 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

163955
D75076

HEALTH DEPARTMENT—CITY OF BALTIMORE

75074 CERTIFICATE OF DEATH. X 49 D75076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Jane Laura Hart

(a) RESIDENCE No. 913 Greenup St., Covington Ky. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 16 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	46	5	54	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Ky.

PARENTS

10 NAME OF FATHER William O'Brien

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Iowa

12 MAIDEN NAME OF MOTHER Ellen Leonard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Iowa

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Records.

15 Filed APR 23 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to April 21, 1923, that I last saw her alive on April 21, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, left cerebellar
dural endothelioma

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Post operative shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of April 21 '23

Was there an autopsy? Yes. parietal head

What test confirmed diagnosis? Operation

(Signed) J. L. Richet, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Covington, Ky. DATE OF BURIAL Apr. 22 1923

20 UNDERTAKER H W Spears & Son ADDRESS 805 Gabriel

mation should be carefully supplied. AGE should be stated EXACTLY. If infant, number of days or hours should be given. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75077 75-075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75077

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Slattery

(a) Residence No. 1425 Eastern Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1886

7-AGE	If LESS than 1 day
36 yrs. ..... mos. ..... ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, Michael McDonald

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Winifred McDoumel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed APR 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 20 1923 to April 20 1923

that I last saw her alive on April 20 1923

and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McCoy M. D.

4-20-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Boston Mass	4/22, 1923
UNDERTAKER J. A. Moran	ADDRESS 3000 E. Balto.

Exact statement of OCCUPATION is very important. Should be entered in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75078 D75078

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 Richardson ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Sebastian

(Residence in Baltimore: No. 1323 Richardson St.; 50 yrs., .. mos. .. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, August 12, 1852 (Month) (Day) (Year)

7-AGE, 70 yrs. .. mos. .. ds.

If LESS than 1 day, .. hrs. or .. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Weaver
(b) General nature of industry, business, or establishment in which employed (or employer): Garment Mfg. Co.

9-BIRTHPLACE, (State or Country). Austria-Hungary

PARENTS.

10-NAME OF FATHER, Nicholas Sebastian

11-BIRTHPLACE OF FATHER (State or Country) Austria-Hungary

12-MAIDEN NAME OF MOTHER Catherine ?

13-BIRTHPLACE OF MOTHER (State or Country) Austria-Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Sebastian

(Address) 1323 Richardson

15-

Filed APR 21 1923, 191.. GILBERT R. KRAUTER COMPANY Burial Permit Clerk

APR 20 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1923, to April 21, 1923, that I saw h[illegible] alive on April 14, 1923, and that death occurred, on the date stated above, at 2 1/4 a.m.

The CAUSE OF DEATH* was as follows:

.. Chronic Interstitial Nephritis (Duration) 3 yrs. .. mos. .. ds.

CONTRIBUTORY (Secondary) .. (Duration) .. yrs. .. mos. .. ds.

(Signed) [signature] M. D.

4-22-, 192.. (Address) 901 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .. yrs. .. mos. .. ds. In the State .. yrs. .. mos. .. ds.

Where was disease contracted, if not at place of death? ..

Former or usual residence ..

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. | DATE OF BURIAL, 4-23-, 1923

20-UNDERTAKER John F. Fahey & Sons | ADDRESS 1318 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75079 D75079

CERTIFICATE OF DEATH.

REGISTERED NO. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melbin Grill

(a) RESIDENCE NO. 1430 Marshall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 13-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Noble Grill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Audrey Heisin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Mrs. Noble Grill (mother) 1430 Marshall St

15 Filed APR 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1923

17

I HEREBY CERTIFY, That I attended deceased from April 21, 1923, to April 22, 1923, that I last saw him alive on April 22, 1923, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillaris pharyngeal (duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) myocarditis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? cultures (+)

(Signed) Bullock, M. D.

4/22/23 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL April 23 1923

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1922 Light St.

IMPORTANT: This certificate should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75080 D75080

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1223 William St. St., 24 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Catherine Mulkern.

(Residence in Baltimore: No. 1223 William St. St.; yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Widow.

6-DATE OF BIRTH. March 15, 1850. 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
73 yrs. 1 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Ireland.

PARENTS.

10-NAME OF FATHER. Michael Moran.

11-BIRTHPLACE OF FATHER, (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Ellen Murray.

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa Mulkern(daughter)

(Address) 1223 William Street.

15- Filed APR 23 1923 192.. ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20, 1923. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart & Kidneys.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Eberhardt M. D.
(Coroner)

Apr. 22, 1923. (Address) 1017 N. Charles St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St. Peters Cemetery	April 23, 1923
20-UNDERTAKER.	ADDRESS.
Margaret S. Fegan	1422 Light St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D75081

HEALTH DEPARTMENT--CITY OF BALTIMORE

D75081

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 Gold ST., 14 WARD)

2-FULL NAME Catherine Brown

(a) RESIDENCE NO. 536 Gold st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Robt Brown

6 DATE OF BIRTH (month, day, and year): 1893.

7 AGE: Years 30 | Months | Days | If LESS than 1 day, ...hrs. or.... min.: 4 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): a. a. co, md

PARENTS

10 NAME OF FATHER: Richard Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant (Address): Robt Brown 536 Gold st

15 APR 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 2, 1923, to Apr 20 1923, that I last saw h alive on Apr 20, 1923 and that death occurred, on the date stated above, at 9.50 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Edema of Lungs

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F Brown, M. D.

4/2/1923 Address) 501 Freedman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dist. of A. A. Co. Md.

DATE OF BURIAL: Apr. 23 1923

20 UNDERTAKER: James W. Dennis

ADDRESS 1313 Freedman

mation should be carefully supplied. AGE should be stated EXACTLY. If child or stillborn, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75082

CERTIFICATE OF DEATH.

31 D75082

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 146 Colvin ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Parkingson

(a) RESIDENCE NO. 146 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): April 10, 1880

7 AGE: Years 43; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Jamaica

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Martha Parkinson

(Address): 146 Colvin

15 Filed APR 23 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1923, to April 19, 1923.

that I last saw him alive on April 19, 1923.

and that death occurred, on the date stated above, at 10:45 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jacob Robinson M. D.

4/19/23 (Address) 1502 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: Apr. 23 1923

20 UNDERTAKER: Wm J. G. Locke ADDRESS: 1302 Jefferson

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75083

CERTIFICATE OF DEATH.

46

D75083

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2107 Greenmount Ave. ST., WARD)

2-FULL NAME Emma Howard O'Neill.

(a) RESIDENCE NO. 2107 Greenmount Ave. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John O'Neill

6 DATE OF BIRTH (month, day, and year) Sept 21 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Saml Howard

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Rebbecca Russell

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant John O'Neill (Address) 2107 Greenmount Ave

15 APR 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4.20. 1923.

17 I HEREBY CERTIFY, That I attended deceased from 4.2.20, 19..., to 4.20.23 19....

that I last saw h[er] alive on 4.19.23, 19....

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 3 yrs. mos 18 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) J Edward Norris, M. D.

4.20. 1923 (Address) 1430 Riversdale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 23 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	733 Hanover St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Benjamin

Spec.—1-10-21—M&T—1500 Blks.

10743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75084

D75084

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. BENJAMIN ST., 12 WARD)

2-FULL NAME Dr. B. F. Lovelace

(a) RESIDENCE NO. Johns Hopkins University ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Alura Lovelace

6 DATE OF BIRTH (month, day, and year) Feb 27 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	47	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Prof Chemistry

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) U. C.

PARENTS

10 NAME OF FATHER B F Lovelace

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. C.

12 MAIDEN NAME OF MOTHER Susan Chapman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U C

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Moore.

15 Filed APR 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17

I HEREBY CERTIFY, That I attended deceased from March 21, 1923, to April 21, 1923, that I last saw him alive on April 21, 1923 and that death occurred, on the date stated above, at 1.26 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis, hypertension. (No cerebral hemorrhage)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insuffi ciency (duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) [illegible], M. D.

4-22 1923 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 24 1923
20 UNDERTAKER	ADDRESS
Henry W Jenkins Sons Co	311 Cullob Orchard Sts

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates.

Spec.—1-10 21—MAT—1500 Blks.

16D765 / 16D75085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75085

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jean Donald

(a) RESIDENCE NO. 1304 Linden Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Donald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Coulter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Johns Hopkins Hospital Md

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 APR 23 1923 ROBERT R. KRAUTER, Registrar of Vital Statistics
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5th, 1923, to April 21st, 1923, that I last saw him alive on April 21st, 1923 and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) yrs. mos. 10 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes M.

What test confirmed diagnosis? No especial test

(Signed) Wortman, M. D.

4-21, 1923 Add. JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 23 1923
20 UNDERTAKER	ADDRESS
Henry H. Jenkins & Son Co	Orchard & Mt Auburn

mation should be carefully supplied. AGE should be stated EXACTLY. Information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D75086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75086

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3009 Frederick Ave. (ST.) (WARD) 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Frederick Hammer

(a) RESIDENCE NO. 3009 Frederick ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Bertha Hammer

6 DATE OF BIRTH (month, day, and year) March 20. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	30	days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Oil Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick August Hammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Arthur C. Hammer (Address) 3009 Frederick Ave

15 Filed APR 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1922, to April 19, 1923, that I last saw h... alive on April 18, 1923 and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

4/21 1923 (Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cem	Apr 23, 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W Balto St

CAUSE OF DEATH is very important. See instructions on back of certificates. Exact statement of OCCUPATION should be carefully supplied. Name of employer must be properly classified

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75087

CERTIFICATE OF DEATH.

117 D75087

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma R. Webb

(a) RESIDENCE NO. 1715 W. Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Webb

6 DATE OF BIRTH (month, day, and year) Nov. 7" 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. H. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Martha A. Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Charles F. Webb

(Address) 538 N. Carey St.

15 Filed APR 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 19" 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to April 19, 1923, that I last saw her alive on April 19, 1923, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Walter A Cox M. D.

4/21 19 23 (Address) 2406 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 23 1923
20 UNDERTAKER	ADDRESS
Joseph L. Cook	1003 W Balto St

Exact statement of OCCUPATION should be carefully supplied. Any statement that it may be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75088

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

23 179

D75088

Registered No. C.....

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Gustav Schlipper.

(Residence in Baltimore: No. 105 W. Ostend St. St.; 48 yrs., 4 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. November 29th. 1874. (Month) (Day) (Year)

7-AGE. 48 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Barber.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George Schlipper.

11-BIRTHPLACE OF FATHER. (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Margaret Makel.

13-BIRTHPLACE OF MOTHER. (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie V. Schlipper. (wife)

(Address) 105 W. Ostend St.

15- FILED APR 23 1923 192 ROBERT R. KRAUTER, Register. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21st. 1923. (Month) (Day) (Year), 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...inquiry... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental 2nd. debree burns about the face and body caused by pouring coal oil into a furnace.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary).....

(Duration)....yrs....mos....ds.

(Signed) Otto M. Einhardt M. D. (Coroner.)

Apl. 22nd 192 3 (Address) 1017 E. Charles St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Accident at 105 W. Ostend St.

Former or usual residence April 20th. 1923.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western	April 23 192 23
20-UNDERTAKER. Geo. J Smith	ADDRESS. 150 Ballard St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D75089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 Woodyear ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gene Rosen.

(a) RESIDENCE. No. 1340 Woodyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Worker in Cone Factory

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Cream Confectioner

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER David Rosen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Estella Hall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ethel Augustine
(Address) 1340 Woodyear

15 Filed APR 23 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22nd 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 14 1923, to Apr. 22nd 1923,
that I last saw h alive on Apr. 22nd 1923,
and that death occurred, on the date stated above, at 1:25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Pathology

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Apr 24 1923

20 UNDERTAKER Edmund E. Wright Funeral Home ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75090

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 Sterling St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hill

(Residence in Baltimore: No. 616 Sterling St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	black	married

6-DATE OF BIRTH. March 10/1883 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
40 yrs. 1 mos. 12 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman
(b) General nature of Industry, business, or establishment in which employed (or employer): R.R.

9-BIRTHPLACE, (State or Country). Nottaway Co. Va.

PARENTS.

10-NAME OF FATHER. George Hill

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Martha Daniels

13-BIRTHPLACE OF MOTHER. (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs George Blake (sister)

(Address) 616 Sterling

15-

Filed APR 23 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Valvular Insuffiency due to endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism- 20 yrs ago

(Duration) yrs. mos. ds.

(Signed) J. S. H. Coleman M. D. (Coroner.)

4/22/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holloway Cem. DATE OF BURIAL. April 23rd 1923

20-UNDERTAKER. Frances Kane ADDRESS 66 McCa

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75091

CERTIFICATE OF DEATH.

109-102

D75091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Durham ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hadler

(a) RESIDENCE. NO. 917 N. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph Hadler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Codella

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Joseph Hadler
(Address) 917 N. Durham

15 APR 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 9. 1923. to April 21. 1923.
that I last saw h— alive on April 21. 1923.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Dysentery Convulsions

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Cardiac Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Gaver M. D.
April 19 (Address) 801 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: April 23. 1923

20 UNDERTAKER: Frank Enoch Son — ADDRESS: 1906 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 75092 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 75092

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Wood (Methia Lilie Wood)

(a) RESIDENCE NO. 727 Franklin st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Tom Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Henrietta Nickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records M.T.H.

15 Filed 4-21-23, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1922, to April 20, 1923, that I last saw her alive on April 20, 1923, and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Padagliacco M. D.

(Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	June 1923

20 UNDERTAKER Greg H. Holland ADDRESS 1631 Main Hilton

231923

IMPORTANT: Should be properly filled out, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75093

1-PLACE OF DEATH Howard A. Kelly Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Inez F. de Franco.

(a) RESIDENCE NO. Bogota, Columbia, S. A. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paulino Franco.

6 DATE OF BIRTH (month, day, and year) Dec. 5/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
62				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Bogata

(State or country) Columbia S. A.

PARENTS

10 NAME OF FATHER Ramon Franco

11 BIRTHPLACE OF FATHER (city or town) Bogota

(State or country) Columbia S. A.

12 MAIDEN NAME OF MOTHER M. Angarita

13 BIRTHPLACE OF MOTHER (city or town) Bogota.

(State or country) Columbia. S. A.

14 Informant Dr. P. Franco.

(Address) Altamont Hotel.

15 Filed APR 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 21 1923,

that I last saw h e alive on April 21, 1923,

and that death occurred, on the date stated above, at 2.25 p m.

The CAUSE OF DEATH* was as follows:

Recurrent carcinoma of breast with metastasis to lungs.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Emphysema. Diabetes Bronchitis.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical. X-rays.

(Signed) Robert E. Fleming M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 24 1923
20 UNDERTAKER	ADDRESS
Geo. F. Keith	1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Nunzio Cangalone (Angalone)

D75094

D75094 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nunzio Angalone (Anzalone)

(a) Residence No. 300 East St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Angalone

6-DATE OF BIRTH (month, day and year) March 25 1879

7-AGE, 45 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Italy

10-NAME OF FATHER, John Cangalone

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy.

12-MAIDEN NAME OF MOTHER, Jennie Buscemi

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

PARENTS.

14- (Informant) Andrew Anzalone

(Address) 322 East 1st

15- FILED APR 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20-23

17- I HEREBY CERTIFY, That I attended deceased from March 19 1923 to Apr. 20 1923

that I last saw h... alive on Apr. 20 1923,

and that death occurred, on the date stated above, at 3 50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac de-

Compensation (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. & Signs.

(Signed) A. J. Scaglione M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Italy Redemp. Cemetery

DATE OF BURIAL, April 22, 1923

20-UNDERTAKER. Louis J. Rutti

ADDRESS 1735 Aisquith

Exact statement of facts must be properly classified. Read carefully and answer in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75095 HEALTH DEPARTMENT—CITY OF BALTIMORE D75095

CERTIFICATE OF DEATH. 101-001

Registered No. 18

1-PLACE OF DEATH

City of BALTIMORE: (No. 1008 N. Fayette St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lena R. Slayton

(a) Residence No. 1008 N. Fayette St., Ward. New York.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of- Edward Slayton

6-DATE OF BIRTH (month, day and year) Unknown 1874

7-AGE. 49 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home work

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). New York

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). New York

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). New York

14- (Informant) Mr. Edgar M. Slayton

(Address) 1008 N. Fayette St.

15- APR 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 20 1923

17- I HEREBY CERTIFY, That I attended deceased from April 13 1923 to April 21 1923

that I last saw h.. alive on April 20 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar - Pneumonia 9

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Compton M. D.

4/21. 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Olivet Cemetery	Apr 24 1923
20-UNDERTAKER. For H. Gleaves Son	ADDRESS. For Hollins St.

- plain terms, so that it may be properly classified.
- structions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 32

City of BALTIMORE: (No. 2793½ Alameda St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Ruth Naylor Garland

(a) Residence No. 2793½ Alameda Ave St., Ward 6

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 21 1919

7-AGE, 1 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William B Garland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Ruth Naylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) William B Garland

(Address) 2793½ Alameda Ave

15- Filed APR 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 21, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to April 21, 1923, that I last saw him alive on April 21, 1923, and that death occurred, on the date stated above, at 4:25 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab Findings

(Signed) Chas. L. Wiring M. D.

, 19 (Address) 3000 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Cemetery — DATE OF BURIAL, April 23 1923

20-UNDERTAKER, John O. Mitchell — ADDRESS 201 N Fayette St

In plain terms, so that it may be properly examined. instructions on back of certificates.

D75097

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-601

D75097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Loraine Caton

(Residence in Baltimore: No. 1217 N. Montford Ave St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	single

6-DATE OF BIRTH. April 21/23, 1..... (Month) (Day) (Year)

7-AGE. .....yrs. .....mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). MD.

PARENTS.

10-NAME OF FATHER, Wm. J. Caton

11-BIRTHPLACE OF FATHER, (State or Country). MD.

12-MAIDEN NAME OF MOTHER, Alice D. Shields

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Caton

(Address) 1217 N. Montford

15- Filed APR 23 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity
(7 months Gestation)

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) J S H Caton M. D. (Coroner)

4/23/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	April 23, 1923
20-UNDERTAKER,	ADDRESS
Frank A. Funk	710 N. Gay St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

Spec.—1-10-23 M&T—1500 Blks.

Ludeck.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75098

CERTIFICATE OF DEATH.

31 D75098

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 565 Longwood ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Ludeck

(a) RESIDENCE NO. 565 Longwood ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. ds. How long in U. S., if of foreign birth? 24 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec 6 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Caroline Engel

(Address) 565 Longwood

15 APR 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923 to April 22, 1923

that I last saw her alive on April 21, 1923

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Jones, M. D.

4-22-23 (Address) 2 Longwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	April 24 1923
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

D75099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75099

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4516 Harford Ave St. 27 Ward) 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick P. Weller

(Residence in Baltimore: No. 4516 Harford Ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. June 8th 1869
(Month) (Day) (Year)

7-AGE. 53 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Louis Weller

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Martha Schroeder

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Argie G. Weller

(Address) 4516 Harford Ave

APR 23 1923 Filed 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 7 or 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(Duration) yrs. mos. 6 ds.

(Signed) J. S. H. Cairns M. D.
(Coroner.)

4/22/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Parkwood Cem.	Apr. 23 1923

20-UNDERTAKER.	ADDRESS
Mr & Mrs. J. W. Teufel & Son	801 N. Fayette

state CAUSE OF DEATH in plain terms, as directed on back of certificate. It is very important. See instructions on back of

D75100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75100

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Loney's Lane & B&O R.R. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Rudorff

(Residence in Baltimore: No. Loney's Lane & B.& O. R.R. St. (yrs. 18) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
male	white	

6-DATE OF BIRTH, January 23/1837, 1.....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
86 yrs. 2 mos. 30 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Formerly
(b) General nature of industry, business, or establishment in which employed (or employer)..... laborer

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Unknown Rudorff

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Walter, (daughter

(Address) 1818 N. Montford Ave

15-

FILED APR 23 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April ~~XXXX~~ 22/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said inquiry (inquest, autopsy or Inquiry.) find that said deceased came to hrs death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficency-due to
Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Taller M. D.
(Coroner.)

4/23/23 192. (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer.	April 24th 1923
20-UNDERTAKER.	ADDRESS
Martin W.E. Dippel	323 S. Ann St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. This is very important. See instructions on back of certificate.

D75101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75101

Registered No. C 177

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna L. Chaney

(Residence in Baltimore: No. 321 S. Durham St.; yrs. 22 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	single

6-DATE OF BIRTH. July 22/1920 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
1 yrs. 9 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). MD.

PARENTS.

10-NAME OF FATHER. Philip Chaney

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Lillian Webb

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Phillip Chaney

(Address) 321 S. Durham

15- FILED APR 23 1923 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22/23 (Month) (Day) (Year) 19..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coal oil poisoning- accidental
(autopsy at hospital)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Oaten M. D. (Coroner)

4/23/23 19.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross Harford Rd	April 24th 1923
20-UNDERTAKER.	**ADDRESS**
Martin W. E. Dippel	375 S. Conn St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. This is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Redies

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75102

CERTIFICATE OF DEATH.

38 D75102

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp St., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Redies

(a) RESIDENCE No. 809 N Eden St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Redies

6 DATE OF BIRTH (month, day, and year) Nov 20th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Maggie Smallwood (Address) 809 N Eden St

15 APR 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 22, 1923, that I last saw her alive on April 21, 1923, and that death occurred, on the date stated above, at 5 20 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency and Thrombosis of cerebral vessel,

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Syphylis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? C. S. & S.

(Signed) John J. Kluge, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem. DATE OF BURIAL April 24 1923

20 UNDERTAKER Les G. Cook ADDRESS North & Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75103

CERTIFICATE OF DEATH.

D75103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Anderson.

(a) RESIDENCE NO. 1830 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 13-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. md

PARENTS

10 NAME OF FATHER: Wm. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. md

12 MAIDEN NAME OF MOTHER: Rose Wild

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. md

14 Informant: Mr Hunner

(Address): 502 Salem Ave

15 Filed APR 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): april 21 1923

17 I HEREBY CERTIFY, That I attended deceased from april 14, 1923, to april 21, 1923, that I last saw h[illegible] alive on april 21, 1923, and that death occurred, on the date stated above, at 9:00 P m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis?

(Signed) H. H. Anderson M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	April 23 1923

20 UNDERTAKER	ADDRESS
Wm Cook	502 E Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75104

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1000 Light St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Myers. Jr.

(Residence in Baltimore: No. 1000 Light St. St.; yrs. 1 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. March 17th. 1923. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
... yrs. 1 mos. 5 ds.	... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Charles H. Myers. Sr.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Margaret Dietz.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Myers Sr. (father)

(Address) 1000 Light St.

15 APR 23 1923 Filed ... 192... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22nd. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Einhardt M. D. (Coroner)

Apl. 22nd. 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	4/23 19...
20-UNDERTAKER. J. Fen McCauley	ADDRESS 1300 E. Fa...

State CAUSE OF DEATH in plain terms, as DEATH may be prosecuted. Neglect to do so is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75105

D75105

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Phila. Ave ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Germaine Rochlitz

(a) RESIDENCE NO. 2804 Phila. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14 - 93

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Milliner

(b) General nature of industry, business, or establishment in which employed (or employer): Herself

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Christopher J. Rochlitz

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Roselia

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Josephine Rochlitz
(Address) 2804 Phila ave

15 APR 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to April 22, 1923.

that I last saw h m alive on April 21, 1923

and that death occurred, on the date stated above, at 9 50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

5 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Hiram Freed M. D.

. 19 (Address) 913 N. Charles Str.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Apr 25 1923

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75106 X38 D75106

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter T. Singleton

(a) Residence No. 1326 Myrtle Ave. St., Ward. South Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1870

7-AGE. 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Wally Singleton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, Frances Jackson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- Filed APR 23 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 5 19 23 to April 20 19 23

that I last saw h. in alive on April 20 19 23

and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis.

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY Hemiplegia

(Secondary) Morphine Addict. 10

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lucas, M. D.

4/21/1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Forest Lawn S.C.	4/25/23
20-UNDERTAKER.	ADDRESS
Saml Hawley	Middleburg

In plain terms, so that it may be properly classified. Exact statement of cause. Full instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002 D75107

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1015 N Mulberry st (St.) 18 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Oakwood.

(a) RESIDENCE: No. 1015 N Mulby st St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): About 1861

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Jas Squirrel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

11 Informant: Doras Washington (Address) 1015 N Mulberry st

15 Filed APR 23 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1923

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1923, to April 20, 1923.

that I last saw her alive on April 20, 1923.

and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
Perforation of Peritonitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Dont Know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T T Jones M. D.

4-23 1923 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 4/23 1923

20 UNDERTAKER: Samuel Handley — ADDRESS: 558 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75108

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 Raborg ST., 18 WARD)

2-FULL NAME Celia Thomas

(a) RESIDENCE NO. 835 Raborg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Pvt

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Wat Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant L. Robinson
(Address) 53 Raborg

15 Filed APR 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1923, to Apl 20, 1923, that I last saw h alive on Apl 20, 1923 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Apl 20, 1923 (Address) 739 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	4-23 1923
20 UNDERTAKER David Easton	ADDRESS 716 Lafayette

mation should be carefully supplied. Exact statement of occu-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tubercular
&
Asthma.

Spec.—1-10-21—M&T—1500 Blks.

D75109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75109

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Elder Alley ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Hynson

(a) RESIDENCE NO. 809 Elder ST, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hynson

6 DATE OF BIRTH (month, day, and year) Dec 4, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Day work Va

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Fletcher Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Florence Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William Hynson

(Address) 809 Elder

15 APR 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 19, 1923, to Apr 21, 1923, that I last saw her alive on Apr 19, 1923, and that death occurred, on the date stated above, at 1015 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

4/21, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-23 1923
20 UNDERTAKER David Eason	ADDRESS 916 Pa ave

IMPORTANT—Should be filled out by undertaker, or person in charge of funeral, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 ✓ D75110

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D75110

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Wilcox St., 10 WARD)

2-FULL NAME Raphael N. French.

(a) RESIDENCE NO. 1215 Wilcox St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19 - 1921

7 AGE — Years: 1 — Months: 6 — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Raphael N. French

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Margaret Caroline .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr. Raphael N. French. (Address) 1215 Wilcox St

15 APR 23 1923 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12 1923, to April 22nd 1923.

that I last saw him alive on April 22nd 1923.

and that death occurred, on the date stated above, at 11.A.M.

The CAUSE OF DEATH* was as follows:

Epithelioma Primaria

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Cachexia (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. H. Kerr, M. D.

(Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL Apr 24 1923

20 UNDERTAKER: John J. Gowan & Son. ADDRESS 901 Hollins St

Caution should be exercised. Exact statement of OCCUPATION may be properly classified, so that it may be properly coded. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75111

CERTIFICATE OF DEATH.

90 D75111

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 N. Chapel ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catharine Eberhardt.

(a) RESIDENCE No. 1809 N. Chapel ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Isidor Eberhardt.

6 DATE OF BIRTH (month, day, and year) Jan. 11th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Francis Zichter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna E. Bishop.

(Address) 1809 N. Chapel St.

15 Filed APR 23 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1922, to Apr. 21, 1923, that I last saw h[illegible] alive on Apr 20, 1923, and that death occurred, on the date stated above, at 6 10 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Fisher M. D.

4/24/1923 (Address) 1823 N. Chapel St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	April 24 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	1419 N. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75112

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D75112

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 S Charles ST., 43 WARD)

2-FULL NAME James H. Diggs

(a) RESIDENCE No. 131 E. 23rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29/1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James H. Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Katrina E. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant James H. Diggs (Address) 131 E. 23rd

15 APR 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 20 1923, that I last saw h alive on April 20, 1923 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

April 21, 1923 (Address) 1644 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	April 24 1923
20 UNDERTAKER	ADDRESS
F. A. Krauter & Son	737 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1300 Blks.

D75113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D75113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rutherside Habbe.

(a) RESIDENCE NO. 100 S. Potomac St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer Lee Habbe

6 DATE OF BIRTH (month, day, and year) April 26/1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Patrick Westhamp

11 BIRTHPLACE OF FATHER (city or town) Staunton (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maggie Mc. Phillips

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Elmer Lee Habbe

(Address) 100 S. Potomac

15 APR 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 20 1923, that I last saw her alive on April 20, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) S W Bowers, M. D.

, 19 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	April 24 1923
20 UNDERTAKER	ADDRESS
Jos. L. Herr	156 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

163644
D75114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D75114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5 WARD) (Ganth)

2-FULL NAME Ella Williams

(a) RESIDENCE No. 165 Colvin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	1	1	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Wantt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Viola Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Baltimore.

15 APR 23 1923 ROBERT N. KRAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to April 20, 1923.

that I last saw her alive on April 20, 1923

and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) A B Weech, M. D.

19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Apr 25 1923
20 UNDERTAKER	ADDRESS
Chas H Wilson & Co	467 Car.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75115 ✓ D75115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 551 E. 38th ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gourley

(a) RESIDENCE No. 551 E. 38th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ (or) WIFE of Capt James Gourley

6 DATE OF BIRTH (month, day, and year) Aug 22 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs Carrie Thorwood (Address) 551 E 38th St

15 Filed APR 23 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr 17, 1923, to Apr 21, 1923,

that I last saw h alive on Apr 21, 1923,

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

& Chr hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Harry Myers, M. D.

4/22, 1924 (Address) 1100 E Int St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 1924

20 UNDERTAKER Henry Leuthy — ADDRESS 1205 Brad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75116

CERTIFICATE OF DEATH.

8 122 - 002

D75116

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1513 Madeira St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl Mannel

(a) Residence No. 1513 Madeira St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Late Mary Mannel

6-DATE OF BIRTH (month, day and year) Sept 5-1844

7-AGE. 78 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Karl Mannel

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) C. F. Mannel

(Address) 1513 N. Madeira St

15- APR 23 1923 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

In plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 21/23

17- I HEREBY CERTIFY, That I attended deceased from April 4, 1923 to April 21, 1923 that I last saw h~~im~~ alive on April 21, 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. Edward Kingwald M. D

4/23/1923 (Address) 1613 E Monument Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Clark Lawn Cem

DATE OF BURIAL. April 24, 1923

20-UNDERTAKER. Wm C. Miller

ADDRESS 2334 Jefferson St

D75117 HEALTH DEPARTMENT—CITY OF BALTIMORE D75117

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 934 Mercy Hospital St. 21 Ward)
2-FULL NAME George E Sheldon.
(Residence in Baltimore: No. 934 Ridgely St.; yrs.... mos.... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-Single, Married, Widow(er), or Divorced. (Write the word.): Married

6-DATE OF BIRTH: April (Month) 18 (Day) 1894 (Year)

7-AGE: 29 yrs. 0 mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Barber Bus.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Balto Md.

PARENTS

10-NAME OF FATHER: John Sheldon
11-BIRTHPLACE OF FATHER (State or Country): Balto. Md.
12-MAIDEN NAME OF MOTHER: Ida Wiss.
13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alice Sheldon.
(Address) 2012 Wilkins St

15-
Filed APR 23 1923 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: April (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

End of April
accidentally drug Elevator
Shaft at 124 S. Calvert.
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) M. Nelson M. D.
(Coroner)
Apl. 22. 1923 (Address) 1614 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park. DATE OF BURIAL: 4-24 1923

20-UNDERTAKER: James Dignan & Son ADDRESS 1000 S Paca St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Item 16 is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

✓ (Reines)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75118

CERTIFICATE OF DEATH.

37

D75118

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 E Hoffman ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kraft

(a) RESIDENCE No. 2414 E Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Rose Kraft

6 DATE OF BIRTH (month, day, and year) June 13. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52.	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Conrad. Kraft.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Louise Baumstadt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Rose. Kraft. (Address) 2414 E Hoffman St

15 APR 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April. 22nd 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 19. 1919. to April 22. 1923.

that I last saw h~~im~~ alive on April 21. 1923.

and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Intestinal infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacillus Physical Signs

(Signed) John D. Peters M. D.

(Address) 706 S. Monument St 4/23/23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Crem.

DATE OF BURIAL 4-25 1923

20 UNDERTAKER Mr Chas G. Rohde

ADDRESS 600 N Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Haus

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

75119

CERTIFICATE OF DEATH.

44 D75119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 Carey ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Hause

(a) RESIDENCE NO. 624 Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Libe

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

~~3-If married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Anna. Haus.

6 DATE OF BIRTH (month, day, and year) Feb. 2 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	77	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar. maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Haus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unbegun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Interment (Address) Mr. L. Stiefler 624 Carey St

15. APR 23 1923 ROBERT J. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~April~~ 22. 1923. to April 22. 1923. that I last saw h~~im~~ alive on April 22. 1923, and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Terminal)

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Acute Cholecystitis

(duration) + yrs. + mos. 30 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & symptoms

(Signed) Charles E. Clark, M. D.

April 23 1923 (Address) Charles E. Clark M.D

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mrs Chas A G. Rohde

DATE OF BURIAL ~~Cremation~~ 4-25 1923

20 ~~UNDERTAKER~~ cemetery Cathedral Cem.

ADDRESS ~~Cremation~~ Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of each item is very important. See instructions on back of certificates.

poc—12-23-21—E. & R.S.—400 Bks.

Damisz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75120

D75120

CERTIFICATE OF DEATH.

179

1

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2204 E. Pratt St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Damisz

(a) Residence No. 2204 E. Pratt St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 10 1849

7-AGE. 73 yrs. 10 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER, James Damisz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) John Damisz

(Address) 2204 E. Pratt

15- Filed APR 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 21 1923

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 21, 1923, that I last saw h.. alive on April 21, 19....., and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(Duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank J. Lamperti, M. D.

4/23, 1923 (Address) 2431 Fait Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary — DATE OF BURIAL. April 24, 1923

20-UNDERTAKER. John Mateker — ADDRESS 1803 Bank St

Instructions on back of certificates.

D75121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75121

CERTIFICATE OF DEATH.

170 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Neal

(Residence in Baltimore: No. 805 S.Caroline St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write out word.)
male	black	married

6-DATE OF BIRTH. unknown (Month) (Day) 1..... (Year)

7-AGE.	If LESS than 1 day,
33 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E.E.Johnson

(Address) 1426 Eastern Ave

15- APR 23 1923 192.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide- pistol shot - entered below left nipple- punctered diaphragmand liver - cause of death hemorrhage (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (operated at hospital (Duration) yrs. mos. ds.

(Signed) J S Haller M. D. (Coroner.)

4/20/23 192.... (Address) 508 E.North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. W.F. Gibbons Lloyd Cemetery

DATE OF BURIAL. 4/23 1923

20-UNDERTAKER. George J Ruth

ADDRESS 1735 Hanford Ave

State CAUSE OF DEATH in plain terms, so that it may be understood. Statement of occupation is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Pks.

Brzozkowski V

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D75122

CERTIFICATE OF DEATH.

D75122

1-PLACE OF DEATH Bayview Hospital

City of BALTIMORE: (No. Elec Block Kora Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.

(a) Residence No. 21 W Baur St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ?

7-AGE.	If LESS than 1 day.
63(?) yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cornet maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14- (Informant) Hospital Records

(Address)

15- Filed APR 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/21/23

17- I HEREBY CERTIFY, That I attended deceased from 3/20/23 19.. to 4/21/23 19..

that I last saw h.. alive on 4/21/23 19..

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis and arteriosclerosis

(Duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. McCoy M. D.

. 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Stanislaus — DATE OF BURIAL. April 25 1923

20-UNDERTAKER. John A Weber — ADDRESS 1803 Bank St

In plain terms, so that it may be properly ... instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75123

D75123

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ethol Terrace & Druid Lane

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Duff

(a) RESIDENCE NO. Ethol Terrace & Maple Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah R. Duff.

6 DATE OF BIRTH (month, day, and year) Oct. 14 1854

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or min.
	69	6.	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) Sarah R. Duff Ethol Terrace & Maple Ave

15 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1923

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to April 22, 1923.

that I last saw h[illegible] alive on April 22, 1923.

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter A. Cox, M. D.

4/25 1923 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL April 1923

20 UNDERTAKER Frank Syfer

ADDRESS Woodland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

23 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75124 D75124

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Seven Mile Lane & Park Heights Ave. ST., 27 WARD)

2-FULL NAME Ann Schofield

(a) RESIDENCE NO. Seven Mile Lane & Park Heights Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Allen Schofield

6 DATE OF BIRTH (month, day, and year) May 2nd 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Alfred Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Amelia Crowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Frank M. Schofield Seven Mile Lane & Park Heights Ave

15 Filed 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22nd 1923

17

I HEREBY CERTIFY, That I attended deceased from ~~March~~ about 1922 to ..... 19.....,

that I last saw her alive on April 22 1923,

and that death occurred, on the date stated above, at 11-30 P m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(duration) ..... yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis. (duration) Unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W. G. Nye, M. D.

4/23. 1923 (Address) Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rondelet R.C.	Apr 23 1923

20 UNDERTAKER Joseph B Cook ADDRESS 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificates.

D75125 HEALTH DEPARTMENT—CITY OF BALTIMORE D75125

CERTIFICATE OF DEATH.

1 × 179

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Laura Williams

(Residence in Baltimore: No. Ellicott City Md. St.; yrs.,.....mos...../..ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	

6-DATE OF BIRTH. Unknown ....., 1..... (Month) (Day) (Year)

AGE. About 1 years. mos. ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none (child)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Benjamin Williams

11-BIRTHPLACE OF FATHER, (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Amanda Poole

13-BIRTHPLACE OF MOTHER, (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address).....

15. Filed 1923 Robert F. Harrison, 192..... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22/23 ....., 192..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd & 3rd burns over more than 1/2 body- accidental- clothing caught fire while starting fire after she had poured oil on fuel (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) ..... (Duration) .....yrs.....mos.....ds.

(Signed) J. S. Wallis M. D. (Coroner.)

4/23/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Burial Western Stars Cem. DATE OF BURIAL. Apr. 27 1923

20-UNDERTAKER. Easton Sons ADDRESS Ellicott City

TAKE CLOSE OF DEATH is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

D75126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2919 Fred Ave ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Hoake

(a) RESIDENCE NO. 2919 Frederick ST. Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 26 1843

7 AGE: Years 79 Months 8 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Allen Hoake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Sullivan S Holmes

(Address) 2919 Frederick

15 Filed 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 1923

17 I HEREBY CERTIFY, That I attended deceased from August, 1921, to April 22, 1923.

that I last saw h[illegible] alive on April 22, 1923

and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) T B. Gastro Enteritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Thos Ravenscroft, M. D.

April 23/23 (Address) 1735 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Apr. 25 1923

20 UNDERTAKER: Easton Sons — ADDRESS: Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAT—1500 Nbs.

D75127

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75127

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 927 Stirling ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Malone

(a) RESIDENCE NO. 927 Stirling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
fem'l	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Daniel Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Denby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mildred Walker

(Address) 927 Stirling St.

15 Filed Robert F. Harrison, Registrar

2 31923 Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to April 20, 1923.

that I last saw h[illegible] alive on April 20, 1923,

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Influenza ?

(duration) yrs. mos. 2 / ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

4/22 1923 (Address) 1520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 24 1923
20 UNDERTAKER	ADDRESS
Joseph T. H. Rochester	[illegible]

D75128 HEALTH DEPARTMENT—CITY OF BALTIMORE D75128

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. Mersey Hospital St., 12 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alonzo C. Martin

(Residence in Baltimore: No. 450 Pinkney Place St. Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. June (Month) 18 (Day) 1891 (Year)

7-AGE. 31 yrs. 10 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundry Marker
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Herman J Martin

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Anna B Graeber

13-BIRTHPLACE OF MOTHER. (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia C Martin

(Address) 450 Pinkney Place

15- 2 3 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 21 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs. Don't Know mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H H Grossmeyer (Coroner.) M. D.

4-23 1923 (Address) 117 N Dallas St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cem	April 25th 1923
20-UNDERTAKER,	ADDRESS
E Schloman & Son	1039 Hanover st

Fill CAUSE OF DEATH very carefully, and be sure that every item of certificate is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

192158
D75129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75129

CERTIFICATE OF DEATH.

X 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Maxwell

(a) RESIDENCE No. Pink Hill, N. C., ST. 12th WARD Pink Hill N.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~mos.~~ ~~ds.~~ How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
~~HUSBAND of~~ ~~WIFE of~~ Leola Maxwell

6 DATE OF BIRTH (month, day, and year) June 27-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	1	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 886
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Jno C.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Caroline Ivey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 Robert T. Harrison, Burial Permit Clerk. Registrar

23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1923, to April 21st, 1923, that I last saw him alive on April 21st, 1923, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia-1

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Thos. W. Cunningham M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kinston N.C.	4/29/23 19
20 UNDERTAKER	ADDRESS
W E Hughes	Hill St. Cordy.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state part of body. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D75130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75130

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 N Luzerne ave ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Henry Burris

(Residence in Baltimore: No. 434 N Luzerne ave St.; 81 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 3 (Month) (Day), 1841 (Year)

7-AGE, 81 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, John A Burris

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Ann Calista Bromley

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Edward Burris

(Address) 434 N Luzerne

15- Robert F. Harrison,

R 23923 ....., 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1923, to April 22 1923, that I saw h[illegible] alive on April 22 1923, and that death occurred, on the date stated above, at 7.18 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

(Signed) Horace B Tudor M. D.

4/22, 1923 (Address) 315 S. Highland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, 4.26.23 191.

20-UNDERTAKER H A Hughes ADDRESS 424 N Broadway

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D75131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75131

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5004 Glenwood Ave ST.; Rackham's WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura La Mates

(Residence in Baltimore: No. 5004 Glenwood Ave St.; 40 yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, June 19, 1858
(Month) (Day) (Year)

7-AGE, 64 yrs. 9 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), St Mary's Co. Md.

PARENTS.

10-NAME OF FATHER, Joshua J Hewett

11-BIRTHPLACE OF FATHER (State or Country) St Mary's Co Md

12-MAIDEN NAME OF MOTHER Mary E. Shirrod

13-BIRTHPLACE OF MOTHER (State or Country) St Mary's Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hughes

(Address) 5004 Glenwood Ave. Rackham

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

2 3 1923

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 22, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 14 1923, to Apr 22 1923, that I saw h.r alive on Apr 22 1923, and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(Duration) yrs. 2 mos. ds.

(Signed) C. Lee Hudson M. D.

4/25/, 1923 (Address) Maple Ave. Belair Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery DATE OF BURIAL, 4/25/, 1923

20-UNDERTAKER C E Hughes ADDRESS 1112 E Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

D75132 ✓ D75132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101-001

4

1-PLACE OF DEATH Mercy Hospital Registered No.

City of BALTIMORE: (No. ... St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McCubbin

(a) Residence No. Granite Md St., Ward Granite Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White.

5-SINGLE, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dec. 22 1861

6-DATE OF BIRTH (month, day and year)

7-AGE. 61 yrs. 4 mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William McCubbin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth McBee.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Jas A McCubbin
(Address) 711 Cary St

15- Robert P. Garrison,
19 Burial Permit Clerk. Registrar.

23 1923

In plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-23-23

17- I HEREBY CERTIFY, That I attended deceased from 4-22- 1923 to 4-23 1923

that I last saw him alive on 4-22 1923

and that death occurred, on the date stated above, at 2 30 M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mo. 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs Symptoms

(Signed) J. F. Gonder M. D.

, 19 (Address) Granite Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Balto Cem. DATE OF BURIAL, 4-24 1923

20-UNDERTAKER, Wm Cook. ADDRESS 502 Main Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75133 D75133

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 N. Chapel ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Smith

(a) RESIDENCE. No. 801 N. Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Bessie Smith.

6 DATE OF BIRTH (month, day, and year) Sept 12, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furnace Hand.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER C P Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER L. Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Bessie Smith

(Address) 801 Chapel St

15 Filed 2 31 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 31 1923

17 I HEREBY CERTIFY, That I attended deceased from April 4 1923, to April 31 1923,

that I last saw h alive on April 31 1923,

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis A. M. Thomas M. D

, 19 (Address) 2500 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	4/24 1923
20 UNDERTAKER Geo Leimbach & Son	ADDRESS 247 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. State statement of disease, and not symptoms. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75134

CERTIFICATE OF DEATH.

74 D75134

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 102 W. Ostend St. 23 WARD)

2-FULL NAME Christian Schmidt.

(a) RESIDENCE. No. 102 W. Ostend St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? 63 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thekla Schmidt.

6 DATE OF BIRTH (month, day, and year) Aug 18, 1851.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 986

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E. Schmidt
(Address) 102 W. Ostend St.

15 FH[illegible] APR 24 1923 APR 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 8, 1923, to April 21, 1923, that I last saw him alive on April 21, 1923 and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney A. Sheath, M. D.

4/23, 1923 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	4/24 1923
20 UNDERTAKER	ADDRESS
L. Fiss Mc Cully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75135

90 D75135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 551 Robert ST., 14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton Hawkins

(a) RESIDENCE No. 551 Robert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH QUESTION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3 - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Lew. Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Lew Hawkins 551 Robert st

15 APR 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 6th, 1923, to Apr. 24, 1923, that I last saw him alive on Apr. 21, 1923, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

, 19 (Address) 1837 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nat Cemetery	Apr 26 1923
20 UNDERTAKER James N. Lewis	ADDRESS 1038 Druid

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75136

D75136

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 Eislen ST. 22 WARD)

2-FULL NAME Child of Walter & Maud Burley

(a) RESIDENCE NO. 416 Eislen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/22/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work dyed (Col)

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) maryland

PARENTS

10 NAME OF FATHER Walter Burley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) maryland

12 MAIDEN NAME OF MOTHER Maud Price

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia

14 Informant Maud Burley
(Address) 416 Eislen St

15 Filed APR 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1923

17

I HEREBY CERTIFY, That I attended deceased from 4/22, 1923, to 4/22, 1923,

that I last saw h[illegible] alive on 4/22, 1923,

and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

8 mos. pregnancy premature
Transverse presentation
maternal Syphilis —

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Delivery by version Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) David Frumkin, M. D.

4/25 1923 (Address) 1818 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	April 23 1923
20 UNDERTAKER	ADDRESS
Thos Geoghegan	40 W. Conway St

Spec.—1-10-21—M&T—1500 Bks.

D75137 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 D75137

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Brentwood ST., 25 WARD)

2-FULL NAME Child of George R. and Alma Lane

(a) RESIDENCE NO. 1225 Brentwood ST., 25 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	6 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo R Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Alma Auschenbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Geo R Lane 1225 Brentwood Ave

15 Filed APR 24 1923 ROBERT K. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to April 23, 1923, that I last saw h[illegible] alive on April 23, 1923 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Newton Kiefer M. D.

April 3, 1923 (Address) 23 W Mad Bard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemy — DATE OF BURIAL April 24 1923

20 UNDERTAKER Jos Joerdens Son — ADDRESS 2178 Penn

CAUSE OF DEATH in plain terms, so that it may be properly classified. State whether from Accident, Suicide or Homicide. See instructions on back of certificates. IMPORTANT.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D75138

D75138

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert P. Ward

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT information is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed APR 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 19 23

17

I HEREBY CERTIFY, That I attended deceased from March 15, 19 13, to April 23, 19 23, that I last saw him alive on April 23, 19 23, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Tbes Dorsalis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McCarty M. D.

4-24 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL 4/25/23 19

20 UNDERTAKER Wm J Jackson ADDRESS 1 Mt Vernon Pl Balto

D75139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75139

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1662 Darley Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Leonard

(Residence in Baltimore: No. 1662 Darley Ave St.; yrs. 13 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	white	[illegible]

6-DATE OF BIRTH. Dec. 8/1856
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
56 yrs. 4 mos. 14 ds.	....hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): U.S.Steamship Co.

9-BIRTHPLACE, (State or Country). London England

PARENTS.

10-NAME OF FATHER. Henry Leonard

11-BIRTHPLACE OF FATHER, (State or Country). England

12-MAIDEN NAME OF MOTHER. Mary Newton

13-BIRTHPLACE OF MOTHER, (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence M. Leonard

(Address) 1662 Darley Ave

15- Filed APR 24 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insuffiency, probably due to a chronic myocarditis. (history of shortness of breath)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cough- Probably branchiti

(Duration) ....yrs. 1 mos. ....ds.

(Signed) J S Haussner M. D. (Coroner.)

4/22/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Apr. 24 192 3

20-UNDERTAKER.	ADDRESS
Henry Horde Son	1301 E Eager St

THIS CASE OF DEATH must be published in full on back of certificate. This is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75140

CERTIFICATE OF DEATH.

129 D75140

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1108 N. Central Ave ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence. F. Murray

(a) RESIDENCE NO. 1108 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary F. Murray

6 DATE OF BIRTH (month, day, and year) March 14 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Supt. Jr

(b) General nature of industry, business, or establishment in which employed (or employer) Eureka Life Ins. Co

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md

PARENTS

10 NAME OF FATHER Thomas Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Louisa V. Herbert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Co Md

14 Informant Mrs Mary F. Murray

(Address) 1108 N Central Ave

15 APR 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1922, to Apr 22, 1923.

that I last saw him alive on Apr 21 1923

and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) uremia

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Thrash, M. D.

, 19 (Address) 821 N Patterson av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Apr 25 1923

20 UNDERTAKER Henry Horch Son — ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75141

CERTIFICATE OF DEATH.

49 D75141

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hennie Pearson

(a) RESIDENCE NO. 1118 W. McDonough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. ds. How long in U. S., if of foreign birth? 59 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Wm. G. Pearson

6 DATE OF BIRTH (month, day, and year) July 6 1864

7 AGE: Years 58 Months 9 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Lewis Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elleanor Trott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mr. William A. Pearson 1118 W. McDonough St

15 APR 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1923, to April 23, 1923; that I last saw her alive on April 23, 1923; and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tumor, Chest

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (over)

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. H. Krauss, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bunclick Mary. Va. DATE OF BURIAL Apr. 25 1923

20 UNDERTAKER Henry Hoech Son ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease or TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75142

CERTIFICATE OF DEATH.

11 V D75142

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 641 W. Lexington ST. 4 WARD)

2-FULL NAME Frances Hilton Byerly

(a) RESIDENCE NO. 641 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lexington N C

PARENTS

10 NAME OF FATHER Jos Byerly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lexington N C

12 MAIDEN NAME OF MOTHER Myrtle Autz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington Mo

14 Informant Myrtle Byerly

(Address) 1641 W. Lexington St

15 FILED APR 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1923

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1923, to April 23, 1923, that I last saw her alive on April 22, 1923, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M.D.

Apl 23 1923 (Address) 2650 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet A. DATE OF BURIAL Apr 25 1923

20 UNDERTAKER A. J. Marshall ADDRESS 3539 Fall Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75143

HEALTH DEPARTMENT—CITY OF BALTIMORE

34 D75143

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital Rd ST., 17 WARD)

2-FULL NAME Henry Strand

(a) RESIDENCE NO. 1119 Shields Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter Strand

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Black

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 APR 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1923

17

I HEREBY CERTIFY, That I attended deceased from February 17, 1923, to April 20, 1923,

that I last saw him alive on April 19, 1923

and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine

(duration) yrs. 6-8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McCoy, M. D.

4-20-23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	4.24 1923
20 UNDERTAKER	ADDRESS
R. L. Parham	2202 Maloney

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75144

CERTIFICATE OF DEATH.

44 D75144

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1309 W Saratoga St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Krieger

(Residence in Baltimore: No. 1309 W Saratoga St.; yrs. 10 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

6-DATE OF BIRTH. Sept (Month) 12 (Day) 1862 (Year)

7-AGE. 61 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Contracting

9-BIRTHPLACE, (State or Country). Germany

PARENTS:

10-NAME OF FATHER. John Krieger

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Susana Hutting

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Weitz

(Address) 1305 W Saratoga St

15- APR 24 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 22 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pyloric end of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

April 23 1923. (Address) 702 Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral — DATE OF BURIAL. April 25 1923

20-UNDERTAKER. Mr Miss M S' Sons — ADDRESS 1737 W Pratt St

State CAUSE OF DEATH in plain terms, so that it may be understood. Do not use abbreviations or technical terms. Omission to state the duration of each cause is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Blks.

Mittelborn

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75145

46 D75145

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 171 Jackson St.: 24 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Mittelborn

(Residence in Baltimore: No. 171 Jackson St.: 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married.

6-DATE OF BIRTH, October 4, 1877
(Month) (Day) (Year)

7-AGE, 45 yrs. 6 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (own) Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Austria-Hungary

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER, (State or Country) Austria-Hungary

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Austria-Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Mittelborn

(Address) 171 S. Jackson St.

15-
APR 24 1923
Filed ..... 191.....
ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1922, to April 1923, that I saw h[illegible] alive on April 22 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) X yrs. mos. ds.

(Signed) [illegible] M. D.

April 23, 1923 (Address) 201 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, April 25, 1923

20-UNDERTAKER Margaret D. Flynn

ADDRESS 1422 Inglis St.

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D75[illegible] HEALTH DEPARTMENT—CITY OF BALTIMORE D75146

CERTIFICATE OF DEATH. 31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 E. 25th St. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia M. Taylor

(a) RESIDENCE NO. 1738 E. 25th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be complete. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 2" 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Robert T. Taylor

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Cecelia Harman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant George H. Taylor
(Address) 1738 E. 25th St.

APR 24 1923 Filed ROBERT A. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 23" 1923

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1923, to Apr. 22, 1923, that I last saw her alive on April 22, 1923; and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia - Pul. tuberculosis.

T. B. pneumonia abt 4 wks

Pneumonia (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) tuberculosis (duration) about 18 mo yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic + X Ray

(Signed) Wm Delaney Thomas M. D.

4/24 1923 (Address) Professional Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem. DATE OF BURIAL Apr. 25 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75147

D75147

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N. Calhoun St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Ann Kennedy

(a) RESIDENCE NO. 14 N. Calhoun St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David I. Kennedy

6 DATE OF BIRTH (month, day, and year) June 23rd 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rockdale Balto. Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Israel Timanus

11 BIRTHPLACE OF FATHER (city or town) Powhatan
(State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Mary E. Timanus

13 BIRTHPLACE OF MOTHER (city or town) Windsor Hills,
(State or country) Md.

14 Informant Mary F. Timanus
(Address) 14 N. Calhoun St.

APR 24 1923 Filed, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 1, 1923, to Apr 23, 1923,

that I last saw her alive on Apr 23, 1923,

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Jones, M. D.

4/23, 1923 (Address) 720 N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Christ Church (Cokesbury)) DATE OF BURIAL Apr 25 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto

Spec.—1-10-21—M&T—1500 Bks.

D75148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75148

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Hebrew Hospital Rutland

CITY OF BALTIMORE: (No. Monument & Wolf ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Joseph L Hahn

(a) RESIDENCE NO. 2425 Lakeview ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Hahn

6 DATE OF BIRTH (month, day, and year) June 27 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~68~~	68	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Adolph Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Adolph Hahn (Address) 2425 Lakeview Ave

15 Filed APR 24 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1923

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1923, to 23, 1923, that I last saw h alive on April 23, 1923, and that death occurred, on the date stated above, at 1:15 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-20-23.

Amputation of right leg above knee

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I Haller Jr M.D., M. D.

4/23, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beth. Hebrew Cem.	4/25/1923
20 UNDERTAKER	ADDRESS
David Sondheim	118 W. Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75149 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75149

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts Entr Pleas ST., 12 WARD)

2-FULL NAME Emily Keller Frostig

(a) RESIDENCE NO. Esplanade Apts Entr Pleas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
f	w	widowed

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ WIFE of Seligman Frostig

6 DATE OF BIRTH (month, day, and year) Aug 28, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Julius Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mathilda Bamberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant Edwin E. Wenger

(Address) 24 Esplanade Apts

15 FILED APR 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922 to April 23, 1923, that I last saw her alive on April 23, 1923, and that death occurred, on the date stated above, at 2.10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. A. H. A. Mayer, M. D.

(Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Ohel Shalom Cem.

DATE OF BURIAL 4/25/1923

ADDRESS 118-20 W. 111th

20 UNDERTAKER David Sondheim Royal Que

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact residence of deceased must be given. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 D75150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 Montebello Terrace. ST., 27 WARD)

2-FULL NAME Mary McIntire

(a) RESIDENCE NO. 140 Montebello Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *******

6 DATE OF BIRTH (month, day, and year) Abt., 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
Abt.	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Maid

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas. Ditman

(Address) 140 Montebello Terrace.

15 APR 24 1929 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 22. 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl. 19. 1923. to Apl. 22. 1923.

that I last saw her alive on Apl. 21 1923;

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Catarrhal inflammation of the gall bladder & duct

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (over)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman M. D.

Apl. 23 1923 (Address) 2314 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 4/24/1923.

20 UNDERTAKER Chas. F. Evans & Son-118 W. Mt. Royal Ave.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75151

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

D75151

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 746 Braeche ST., 4 WARD)

2-FULL NAME Annie Williams

(a) RESIDENCE NO. 746 Braeche ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Cases [illegible] on back of certificate. TION is very important. See instructions on b

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Negro

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Randolph Williams

6 DATE OF BIRTH (month, day, and year) 1/29/73

7 AGE Years 50 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Burke's Sta. Va.

PARENTS

10 NAME OF FATHER Joshua Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Burkes Sta. Va.

12 MAIDEN NAME OF MOTHER Martha Pearson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Burkes Sta. Va.

14 Informant (Address) Randolph Williams 746 N. Braeche ST

15 Filed APR 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/24/, 1923, to 4/23, 1923, that I last saw [illegible] alive on 4/23/, 1923 and that death occurred, on the date stated above, at 8 am

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

Following Grippe (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. L. Jackson M. D.

4/23 1923 (Address) 767 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burkeda — DATE OF BURIAL April 25 23

20 UNDERTAKER George H. Holland — ADDRESS 1631 N [illegible] Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

D75152 D75152

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH Found in waters Pond 182

City of BALTIMORE: (No. Mt Winans St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Stewart

(Residence in Baltimore: No. 1338 Division St St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	colored	Single

6-DATE OF BIRTH. Unknown (Month) (Day) 18?? (Year)

7-AGE. 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Train Porter
(b) General nature of industry, business, or establishment in which employed (or employer). B & O. R.R.

9-BIRTHPLACE. (State or Country). Maryland

PARENTS

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Susan Jones

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Farrell Rawlins

(Address) 1338 Division St

15- ROBERT R. KRAUTER,

APR 24 1923 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21 (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning in Waters Pond - Mt. Winans

Accident

(Duration) yrs. mos. Sudden ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner)

April 24 1923 (Address) 7 W Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Laurel Cem DATE OF BURIAL. 4/24/23

20-UNDERTAKER. Sam'l Hemsley ADDRESS Middletown

State CAUSE OF DEATH in plain terms. Indefinite answers are worthless. If from accident, state when and where occurred. If from violence, state whether suicidal, homicidal or accidental. If from casualty, state whether it occurred in mine, factory or workshop. If from typhoid fever, state whether any sanitary defects found in house or premises. If from tuberculosis, state what form. If from cancer, state what part affected. If from any disease of women, state whether single, married, widowed or divorced. If from childbirth, state whether single or married. If from any disease of infancy, state whether legitimate or illegitimate. This certificate is very important. See instructions on back of certificate.

D75153 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75153

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 904 N. Milton Ave St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank KOSINSKI

(Residence in Baltimore: No. 507 S. Clinton St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

6-DATE OF BIRTH September 2/1888
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
34 yrs. 7 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work: Clothes-Presser 080
(b) General nature of industry, business, or establishment in which employed (or employer): Good-Will Industries

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country), "

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Veteran's Bureau

(Address) 22 Light St.

15-

Filed APR 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Insuffiency
probably due to endocarditis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Rheumatism dating to or before service in army (1919/20)
(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

4/23/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
National Cemetery	4/24 1923
20-UNDERTAKER.	ADDRESS 1127 E Balto St
S. Lawson & Bro	

state CAUSE OF DEATH in plain terms, so that it can be understood by a layman. This information is very important. See instructions on back of certificate.

D75154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17° D75154 Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Patterson Park St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacobi Biondi Unknown

(Residence in Baltimore: No. ~~1503 W. Fayette~~ St.; yrs., mos. ds.)

Male.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Unknown 1..... (Month) (Day) (Year)

7-AGE. about 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Attending training
(b) General nature of industry, business, or employer for whom employed (or employer): Naval U. S. V.

9-BIRTHPLACE. (State or Country). Ill.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
U.S.V. Bureau (Informant)
72 Light St (Address)

15- APR 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Apr 19 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage Brain
Shot Self in R. Temple

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. E. Norton M. D.
Coroner.
Apr 20 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. Suicide

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Hebrew Mt Carmel	4/24 1923
20-UNDERTAKER. N. Funeral Home	ADDRESS 1127 E Balto st

state CAUSE OF DEATH in plain terms, so that it may be understood by a layman. Do not use abbreviations or technical terms. Statement of duration of each cause is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75155

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 D75155

CERTIFICATE OF DEATH.

5

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Orleans ST.; WARD)

2-FULL NAME Richard Colbert.

(a) RESIDENCE. No. 1208 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 0 mns. 0 ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Colbert.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Yard.

(c) Name of employer C. Hoffberger & Co.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Colbert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Jennie Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

11 Informant Mary Colbert (Address) 1208 Orleans ave

15 Filed APR 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1923

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1923, to April 22, 1923, that I last saw h alive on April 21, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? General symptoms.

(Signed) Chas. J. Reutaldt, M. D.

, 19 (Address) 321 S. B'way.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Severn Md.	April 25 1923
20 UNDERTAKER Mrs Robert & Elliott	ADDRESS 1725 Oakland

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D75156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75156

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 So. Spring St St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Vaznonis (Vasnonis) 30

(Residence in Baltimore: No. 117 So. Spring St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Unknown 1.....
(Month) (Day) (Year)

7-AGE About 35 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 080

9-BIRTHPLACE, (State or Country) Lithuania

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Lithuania

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Grebliauckas

(Address) 417 S. Paca St

APR 24 1923 Filed..... 192.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr 23rd 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

192.. (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	April 25 19 23

20-UNDERTAKER.	ADDRESS
John Grebliauckas	425 S. Paca St.

99

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-002 D75157

D75157

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Mount Hope Retreat ST. 28 WARD)

2-FULL NAME Miss Mary Ryan

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? Nonres/Resmos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Malachi Ryan

6 DATE OF BIRTH (month, day, and year) March 12, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	68	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer) Sewing -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Ireland -

PARENTS

10 NAME OF FATHER Edward Carroll

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland -

12 MAIDEN NAME OF MOTHER Ann Fleming.

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland.

14 Informant Miss Katherine Carroll
(Address) 103 Monument E

15 APR 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2nd 1922, to Apr 22, 1923, that I last saw her alive on Apr 22, 1923, and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Paralysis - Paraplegia - Cerebral Atherosclerosis Senile -

(duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 25 1923
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	914 E. Eager St

Spec.—1-10-21—M&T—1500 Bks.

D75158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D75158

REGISTERED NO.....

1-PLACE OF DEATH 1227 N Bond St., (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1227 N. Bond St., ST., 8 WARD)

2-FULL NAME John Henry Schmalbach

(a) RESIDENCE NO. 1227 N Bond St., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Henry Schmalbach

11 BIRTHPLACE OF FATHER (city or town) Berlin.
(State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Gunther

13 BIRTHPLACE OF MOTHER (city or town) Berlin
(State or country) Germany

14 Informant Mrs. W. Neumann (Niece)
(Address) 4898 Resiterstown Rd

15 Filed APR 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to April 21, 1923, that I last saw him alive on April 4, 1923, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
Senile Arteriosclerosis
Nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Chronic Cystitis
(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.
April 24, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 4/25 1923

20 UNDERTAKER: Harry H. Witzke. — ADDRESS: 1530 W. Lombard St.

IMPORTANT—Should be carefully written, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75159 HEALTH DEPARTMENT—CITY OF BALTIMORE D75159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 Small St., 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Ed Young

(Residence in Baltimore: No. 1318 Small St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. M

4-COLOR OR RACE. B.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Dec 8 1922
(Month) (Day) (Year)

7-AGE. about 1 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. No.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country) Balto

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER. (State or Country) Not known.

12-MAIDEN NAME OF MOTHER. Not known.

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed APR 24 1923 192

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 21 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin R Yates M. D.
(Coroner)

(Address) 423 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL. ..... 19...

20-UNDERTAKER. Commissioner Health.

ADDRESS APR 24 1923

...state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each ...is very important. See instructions on back of certificate.

D75160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75160

CERTIFICATE OF DEATH.

159-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3618 Dillon St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sand Fosmand

(Residence in Baltimore: No. 3618 Dillon St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	B.	Single

6-DATE OF BIRTH Apr 18 / 23 1.....
(Month) (Day) (Year)

7-AGE. .....yrs.....mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER. —

11-BIRTHPLACE OF FATHER, (State or Country). —

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER, (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed APR 24 1923, 192.... Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Apr. 22 / 23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Apr 23 - (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Laudanum

.....(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) —

.....(Duration).....yrs.....mos.....ds.

(Signed) G. C. Blades M. D.
(Coroner.)

Apr 24 1923 (Address) 1436 Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL	....., 19....

20-UNDERTAKER. Commissioner Health, ADDRESS APR 24 1923

To state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of certificate. This is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75161

D75161

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp ST., 25 WARD)

2-FULL NAME William B. Gladsky

(a) RESIDENCE NO. Rock Hall Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? 41 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna M. Gladsky

6 DATE OF BIRTH (month, day, and year) July 18, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59 Yrs.	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Germany
(State or country)

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) ..... " "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) ..... " "
(State or country)

14 Informant ..... Stanley Gladsky
(Address) ..... Rock Hall Md

15 Filed ..... 19 ..... Registrar Robert P. Harrison,

24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1923, to April 27, 1923, that I last saw him alive on April 24, 1923, and that death occurred, on the date stated above, at 7 15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.
Cirrhosis of Liver.

..... (duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward H. Kidlowski, M. D.

Apr 24 1923 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Rock Hall Kent Co. Md. DATE OF BURIAL Apr 25 1923

20 UNDERTAKER Wm. Mus. J. W. Tenfelt & Son ADDRESS 801 A. Fayette St.

mation should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Alcoholic

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75162 ✓ D75162

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH •

CITY OF BALTIMORE: (No. 3908 Fait. ST., 26 WARD)

2-FULL NAME Mary Anna Kollinger

(a) RESIDENCE NO. 3908 Fait ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? 62 yrs. 10 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caston P. Kollinger

6 DATE OF BIRTH (month, day, and year) May 27-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	62	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) ..... at home

(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Frank J. Wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Caston P. Kollinger
(Address) 3908 Fait Ave

15 Robert P. Harrison, Registrar

R 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 7 ....., 1923, to April 22 1923, that I last saw h.r alive on April 19, 1923, and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

~~Cerebral Hemorrhage~~ Cerebral Hemorrhage

(duration) yrs. 4½ mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Cerebral Hemorrhage

(duration) yrs. 4½ mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Held, M. D.

Nov. 19 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL April 25 1923

20 UNDERTAKER Lilly & Zeller — ADDRESS 403 S. W...

mation should be correctly supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75163 ✓ D75163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75163 3 31

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital, St., 3 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen McLeod

(a) Residence No. 1415 Eastern Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1847

7-AGE.	If LESS than 1 day,
75 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Scotland

PARENTS.

10-NAME OF FATHER. Norman McLeod

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Scotland

12-MAIDEN NAME OF MOTHER. Jennie Gillis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Scotland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 1923 Robert P. Garrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 22, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 19, 1923 to April 22, 1923 that I last saw him alive on April 22, 1923 and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis ✓

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Hans Zinsser M. D.

4-23-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Trinity Cemetery	4/25/23

20-UNDERTAKER.	ADDRESS
R. E. Hughes & A. Boudray	

R 24 1923

Exact statement of occupation is required. In plain terms, so that it may be properly classified. See instructions on back of certificates.

D75164

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75164

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Park Ave nr Harford Ave St. (Hamilton Ward) 27 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary W. Kauffman

(Residence in Baltimore: No. Park Ave nr Harford Ave St.; yrs. 4p mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	Widow

6-DATE OF BIRTH. January 15/1859
(Month) (Day) (Year)

7-AGE. 64 yrs. 3 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Joshua Foreman

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Sarah E. Boyd

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ira J. Kauffman

(Address) Park Ave nr Harford

15- Robert F. Harrison, Registrar.
192
Burial Permit Clerk.

APR 24 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23/23, 192
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency-due
probably fatty infiltration-
obesity
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion
(Duration) yrs. mos. ds.

(Signed) J. S. H. Gallus M. D.
(Coroner.)

4/24/23 192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore County	Apr. 25 1923
20-UNDERTAKER.	ADDRESS
J. W. Cook	502 E. 40 Ave

It may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate. State CAUSE OF DEATH in plain terms, so that

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75165

CERTIFICATE OF DEATH.

161-001 D75165

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1614 McHenry St.; 19 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Philip A. & Mary A. Dieglein

(Residence in Baltimore: No. 1614 McHenry St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOW(ER), OR DIVORCED. (Write the word.) Baby

6-DATE OF BIRTH, April 24, 1923. (Month) (Day) (Year)

7-AGE, ... yrs. ... mos. ... ds. If LESS than 1 day, 12 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Philip A. Dieglein

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER Mary A. Sparrow

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip A. Dieglein

(Address) 1614 McHenry St

15- Robert P. Harrison,

Filed ..., 191... Registrar.

24 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 24 1923, to Apr 24 1923, that I saw h[illegible] alive on Apr 24 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

... (Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

..., 191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery. DATE OF BURIAL, Apr 25, 1923.

20-UNDERTAKER Harry H. Witz Co. ADDRESS 1531 W Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75166

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75166

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 837 Hamilton Terrace St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Adger Clarke

(a) Residence No. 837 Hamilton Terrace St., Ward Florida,

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 78 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) August-?-1844

7-AGE. 78 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) Augusta (State or Country) Georgia

PARENTS.

10-NAME OF FATHER, Samuel Clark

11-BIRTHPLACE OF FATHER (city or town) Augusta (State or Country) Georgia

12-MAIDEN NAME OF MOTHER, Elizabeth Moore

13-BIRTHPLACE OF MOTHER (city or town) Augusta (State or Country) Georgia

11- (Informant) Mrs M Bibright

(Address) 837 Hamilton Terrace

15- APR 25 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4th 24th 1923

17- I HEREBY CERTIFY, That I attended deceased from 4th-23rd 1923 to 4th 23rd 1923 that I last saw her alive on 4th-23rd 1923 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Gastritis & Enteritis

(Duration) 2 yrs. ? mos. ? ds

CONTRIBUTORY (Secondary) Mitral insufficiency & Age (Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Tests

(Signed) D A Waldram M. D

, 19 (Address) 210 East Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Augusta Ga

DATE OF BURIAL. 4/25, 1923

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

d. Exact statement of OCCUPATION is necessary. Should be carefully worded, so that it may be properly classified. Express in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75167

D75167

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1007 S. East ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur F. Walker

(a) Residence No. 1007 S. East ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 22d 1914

7-AGE.	If LESS than 1 day,
8 yrs. 4 mos. 2 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, Arthur Walker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York

12-MAIDEN NAME OF MOTHER, Annie Meilohn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Annie Walker

(Address) 1007 S. East Ave

15- APR 25 1923. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 24-1923

17- I HEREBY CERTIFY, That I attended deceased from April 4 1923 to April 24 1923

that I last saw him alive on April 24 1923

and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Septic pneumonia

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Gunell M. D.

4/25, 1923 (Address) 633-5-3rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lutherville Cemetery	April 25, 1923
20-UNDERTAKER.	ADDRESS
Sinkler & Sinkler	1729 E. Eager St.

In plain terms, so that it may be properly classified. Print. Exact statement of cause. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75168 ✓ D75168

D75168

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Johnson

(a) Residence No. 48 S. Stockston St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1865

7-AGE.	If LESS than 1 day,
57 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Alfred Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Record

(Address)

15- Filed APR 25 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 22, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 31, 1923 to April 22 1923.

that I last saw him alive on April 21 1923.

and that death occurred, on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hart Failure

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) J. A. Mackenzie, M. D.

4-23-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
M Cemetery	4/25 1923
20-UNDERTAKER. Samuel P. Hennessy	ADDRESS 578 W Baltimore

In plain terms, so that it may be properly classified. Back statement of cause of death. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 D75169

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 231 S Castle St ST., W WARD)

2-FULL NAME Julia Delaney

(a) RESIDENCE No. 231 S Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yr yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Delaney

6 DATE OF BIRTH (month, day, and year) May 25 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Delaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Delaney

(Address) 231 S Castle St

15 Filed APR 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 4 1923 to April 23 1923, that I last saw h[illegible] alive on April 23 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) " " "

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. F. Elder M. D.

(Address) 1937 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL April 26 1923

20 UNDERTAKER Robt J Turner

ADDRESS 1442 E Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of conditions on back of certificate. See instructions on back of certificate. Information should be very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75170 HEALTH DEPARTMENT—CITY OF BALTIMORE D75170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 167

CITY OF BALTIMORE: (No. 804 Dukeland ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie Catherine Simms.

(a) RESIDENCE. NO. 804 Dukeland ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick W. Simms.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary F. Jacobs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Fred W. Simms
(Address) 804 Dukeland St

15 APR 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16 1923. to April 24. 1923.
that I last saw her alive on April 24. 1923.
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Measles.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm Michel M. D

April 24 1923 (Address) 2901 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington	4-25 1923
20 UNDERTAKER Wm Eichhorn	ADDRESS 916 Penna Ave

mation should be given. Illegible, illegal or incomplete certificates will be returned for correction. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75171

CERTIFICATE OF DEATH.

101-001 D75171

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 N. Vincent ST., 16 WARD)

2-FULL NAME Hattie Johnson

(a) RESIDENCE NO. 924 N. Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Thos. Johnson

6 DATE OF BIRTH (month, day, and year) May 20 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Elias Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thos. Johnson

(Address) 924 N. Vincent St.

15 APR 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 21 - , 1923 , to Apr. 23 - , 1923 , that I last saw her alive on Apr. 23 - , 1923 , and that death occurred, on the date stated above, at 2-20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) - yrs. - mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Sym.

(Signed) Chas. L. McCutchen, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	4-25 1923
20 UNDERTAKER David Carter	ADDRESS 924 N. Vincent

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75172

57. D75172

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 N. Wheeler Ave. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constance Fiore

(a) RESIDENCE NO. 34 N. Wheeler Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Remuoldo Fiore

6 DATE OF BIRTH (month, day, and year) June 21-1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
66	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Cosmo Alaure

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Remuoldo Fiore

(Address) 34 N Wheeler Ave.

15 Filed 19 APR 25 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1 1923, to Apl 23. 1923.

that I last saw her alive on Apl 23 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diabetes.

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Herbert C. Blake, M. D.

, 19 (Address) 1014 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Catheral Cemetery	Apr. 26 1923
20 UNDERTAKER	ADDRESS
George L. Schwab	2101 Fredk. AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Miners

1923
70
1883

D75173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D75173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822½ Pamish St ST., 16 WARD)

2-FULL NAME Annie Winters

(a) RESIDENCE NO. 822½ Pamish St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawson Winters

6 DATE OF BIRTH (month, day, and year) March 28 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Emil Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Ware

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lucie Williams

(Address) 1106 Rugby Ave

Filed APR 25 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14 - 1923, to Apr. 24 - 1923, that I last saw her alive on Apr. 24 - 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute gastritis

(duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos. C. McCardell, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Apr 27th 1923

20 UNDERTAKER Harman & Wyghl — ADDRESS 1364 W Lanv

mation should be correctly supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75174

CERTIFICATE OF DEATH.

X90

1-PLACE OF DEATH
CITY OF BALTIMORE—(NO. St. Josephs Hospital ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Lawson

(a) RESIDENCE NO. Buckhannon W. Va WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 4 yrs. 1 1/2 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~: Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of J A. Lawson

6 DATE OF BIRTH (month, day, and year) 7 | 16 | 1861

7 AGE: Years 61 | Months \ | Days \ | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Buckhannon Rum
(State or country) Lewis Co. W Va

PARENTS
10 NAME OF FATHER E. Robinson
11 BIRTHPLACE OF FATHER (city or town)
(State or country) W. Va
12 MAIDEN NAME OF MOTHER Markell
13 BIRTHPLACE OF MOTHER (city or town) W Va
(State or country)

14 Informant Mr Robert Lawson
(Address) 42 College Ave Buckhannon W Va

Filed APR 25 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1923, to April 25, 1923, that I last saw her alive on April 26, 1923, and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Toxic Goitre

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/23/23 April 23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P W Rousey, M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buckhannon W. Va.
DATE OF BURIAL 4/25 1923

20 UNDERTAKER George J Ruth
ADDRESS 1725 Hartford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D75175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75175

X 57

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Don Secours Hospt ST., 20 WARD)

2-FULL NAME Samuel Cavanaugh

(a) RESIDENCE NO. Liberty town Md ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 SEX: Male

5 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of Industry, business, or establishment in which employed (or employer): R C Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Record

(Address)

APR 25 1923. ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5 1923 to April 24 1923, that I last saw him alive on April 24 1923, and that death occurred, on the date stated above, at 8 60 P m.

The CAUSE OF DEATH* was as follows:

ac Bronchopneumonia

ac Tonsilitis

ac Polyarthritis

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Chr Myocarditis & Diabetes

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of N.A.

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) J. A. Dorsey, M. D.

4-26-1923 (Address) 604 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Liberty town Md — DATE OF BURIAL 4/27/23

20 UNDERTAKER: Gorsuch Finley Fulton — ADDRESS Ridgely

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D75176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75176

CERTIFICATE OF DEATH.

75-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1750 E. Lombard ST.; 2 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith A. Ruark

(Residence in Baltimore: No. 1750 E. Lombard St.; 25 yrs., ... mos., ... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November (Month) 12 (Day) 1853 (Year)

7-AGE, 69 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Carroll County Maryland

PARENTS.

10-NAME OF FATHER, Harry Pickett

11-BIRTHPLACE OF FATHER (State or Country) Carroll Co. Md

12-MAIDEN NAME OF MOTHER Mary Jenkins

13-BIRTHPLACE OF MOTHER (State or Country) Carroll Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. T. Ruark

(Address) 1750 E. Lombard St

15- APR 25 1923 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1923, to April 24 1923, that I saw h[er] alive on April 24 1923, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Tumor, uterus due to
Myoma Uteri
(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia
(Duration) ... yrs. 1 mos. ... ds.

(Signed) Jos. L. Valentine M. D.

April 25, 1923. (Address) 14 So. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, April 26, 1923

20-UNDERTAKER McInnis-Berrell Co — ADDRESS 2285 Ridgewood

Spec—12-23-21—E.B.R.S.—400 Bks.

D75177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D75177

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 512 Rosemont Ave St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Rachel Jane Markland

(a) Residence No. 512 Rosemont Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-(Write the word—Single, Married, Widowed, or Divorced) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William F.

6-DATE OF BIRTH (month, day and year) Nov 23 1856

7-AGE, 66 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Alpheus Green

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mc- Kenna

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md Kenna

14- (Informant) Clarence W. Markland

(Address) 512 Rosemont Ave

15- Filed APR 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/24/23

17- I HEREBY CERTIFY, That I attended deceased from Mch, 1914 to Apr, 1923, that I last saw h. alive on Apr 21, 1923, and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of the arteries

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Chas. W. Mullen, M. D.

4/24, 1923 (Address) 512 Rosemont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, 4/27, 1923

20-UNDERTAKER, Wm Cook — ADDRESS 522 E. N. Ave

In plain terms, so that it may be properly classified. Read instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

~~Syphilis~~

Had been cured
6 yrs ago.
Phone Messages.

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75178 — 129 — 75178

1-PLACE OF DEATH University Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Greene St. 21 WARD)

2-FULL NAME Wm Fleming

(a) RESIDENCE NO. 921 Ryan St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat washer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prussia

PARENTS

10 NAME OF FATHER Robt. Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Oliver ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Buckholtz
(Address) 921 Ryan St

15 Filed APR 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1923, to 4/24, 1923.

that I last saw him alive on 4/24, 1923,

And that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? outside

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Thos Jordan, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — London Park — DATE OF BURIAL 4/27 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E. N. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75179

D75179

CERTIFICATE OF DEATH.

REGISTERED NO. 2

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Holiwood Apts. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patricia Mary Berg.

(a) RESIDENCE NO. Camp Holabird ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Harry Berg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Minnesota

12 MAIDEN NAME OF MOTHER Clara DeGray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Clara Berg (Address) Camp Holabird Apts

15 Filed APR 25 1923 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 23, 1923, that I last saw him alive on April 23, 1923, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A.W. Reier, M. D.

4/23 1923 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Port Royal Juniatta Pa | DATE OF BURIAL Apr 26 1923

20 UNDERTAKER John Ellrich | ADDRESS 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75180

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE (No. 726 Poplar Grove St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise M Mrs Brile

(Residence in Baltimore: No. 726 Poplar Grove St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. January (Month) 28 (Day) 1875 (Year)

7-AGE. 48 yrs. 2 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). France

PARENTS:
10-NAME OF FATHER. Victor Pantigny
11-BIRTHPLACE OF FATHER. (State or Country). France
12-MAIDEN NAME OF MOTHER. Pauline Loubard
13-BIRTHPLACE OF MOTHER. (State or Country). France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Angele M. Morris
(Address) 726 Poplar Grove St.

15- Filed APR 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 23 (Month) (Day) 23 (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis
(Duration) ....yrs. 1 mos. ....ds.
CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) G. C. Klein M. D.
(Corner) Apr 24 23 (Address) 4316 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery DATE OF BURIAL. Apl 25 1923

20-UNDERTAKER. Jos Syfer ADDRESS 1600 N North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75181

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D75181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2137 N. Pulaski St St. 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret V. McDonald

(a) Residence No. 2137 N. Pulaski St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND ~~of (or)~~ WIFE of John H. McDonald

6-DATE OF BIRTH (month, day and year) January 13/1859

7-AGE. 64 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Montgomery Co Md

PARENTS

10-NAME OF FATHER, William Parsley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Montgomery Co Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Norman C McDonald

(Address) 512 Norman Ave

15- Filed APR 25 1923 19.. ROBERT H. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 24-1923

17- I HEREBY CERTIFY, That I attended deceased from Apr 14 1923 to Apr 24 1923 that I last saw h[er] alive on Apr 23 1923 and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular.

(Signed) H. Goodwin M D

Apr 24 1923 (Address) 313 W. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL, Apl 26 1923

20-UNDERTAKER. Jos. Syfert — ADDRESS 1600 W. North Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D75182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 - Mattui ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Allen.

(a) RESIDENCE. No. 1710 Mattui ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 20, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	19	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charlottesville Va.

PARENTS

10 NAME OF FATHER Alex Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlottesville, Va.

12 MAIDEN NAME OF MOTHER Maria Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlottesville Va.

14 Informant Miles Lee (Address) 616 N. Bond St

15 FILED APR 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 23, 1923, that I last saw h— alive on April 23, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) R. A. Johnson, M. D.

, 19 (Address) 211-E-25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Branch Va. DATE OF BURIAL: April 25 19

20 UNDERTAKER: Brown & Ireland ADDRESS 114 Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75183

CERTIFICATE OF DEATH.

129 D75183

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N Dallas ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Mitchell

(Residence in Baltimore: No. 518 N Dallas St.; 58 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Feb 26, 1865 (Month) (Day) (Year)

7-AGE, 58 yrs. 1 mos. 29 da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Lloyd

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ellen Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Woods

(Address) 518 N Dallard

15-APR 25 1923 Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24 - 1923, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5/2/16 191..., to 4/23/23 191..., that I saw her alive on 4/23/23 191..., and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis c
hypertension

(Duration) 7 yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) 7 yrs. ..... mos. ..... da.

(Signed) J. A. McKay M. D.

....., 191... (Address) Bayview Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence 518 N. Dallas St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, April 26 1923

20-UNDERTAKER R. L. Gross — ADDRESS 1405 McElderry

N. B.—Every question must be answered in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Size—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75184 D75184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Sister Sisters on the Fore St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Washington

(a) Residence No. Preston Valley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1853.

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Sister Florence

(Address) Preston & Valley

15- Robert F. Harrison, 19

Registrar.

R 257923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 23 24

17- I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw h. alive on April 22 19 23

and that death occurred, on the date stated above, at 8.45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

1 week (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cons

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Wiese M. D.

19 (Address) 1133 Valley

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Trinity

DATE OF BURIAL. April 26 1923

20-UNDERTAKER. H. C. Wiedefeld

ADDRESS 914 Greenmount Ave

Exact statement of OCCUPATION is necessary. Use plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75185

CERTIFICATE OF DEATH.

93

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 Brentwood Av. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L. Wintz

(a) RESIDENCE NO. 1127 Brentwood Av. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Regina L. Wintz

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vocational Training

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Aloysius Wintz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Murry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Regina L. Wintz

(Address) 1127 Brentwood Av.

15 L. Harrison,

19 Registrar

25 1923 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23, 23 19

17

I HEREBY CERTIFY, That I attended deceased from Apr 4, 1923 to Apr 23 1923.

that I last saw him alive on Apr 23, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolis

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) Thrombo-Phlebitis

(duration) yrs. 4 mos. 2 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4-5-23

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter A. Munnich, M. D.

19 (Address) Fort McHenry N.S. Pier 5 Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	April 27 1923
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75186

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D75186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 S Elwood Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Hrica

(a) RESIDENCE No. 1204 S Elwood Ave ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life Yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs — mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-23-22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Steve Hrica

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Wetkowsky

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

14 Informant Steve Hrica (Address) 1204 S Elwood Ave

15 Robert F. Harrison, M.D. Registrar

Burial Permit Clerk

APR 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 19... to Apr 25, 19 23, that I last saw her alive on April 24, 19 23, and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis? Physical Signs

(Signed) Chas. O. Heer M. D.

4/25/23 (Address) 405 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Hamilton Bklyn	4-27 1923
20 UNDERTAKER Stephen J. Fiackowski	ADDRESS 1200 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D75187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3008 McKaye Court ST.: 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred D. Knight

(a) RESIDENCE. No. 3008 McKaye Court WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred since birth ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec 27 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Feldman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant James Knight (Address) 3008 McKaye Ct.

15 Filed Robert J. Harrison, Registrar

25 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to April 24, 1923, that I last saw h[illegible] alive on April 24, 1923, and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) gastro enteritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

4-27-1923 (Address) 6314 S. Elwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Cem	April 26 1923
20 UNDERTAKER Stephen H. Walkowski	ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75188

CERTIFICATE OF DEATH.

112 D75188

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat St. 28th Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfreda P. Harwood

(a) RESIDENCE. No. Mt Hope Retreat St. 28 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? 26 yrs. 6 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 - 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	26	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Chas. W. Harwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER M. L. Haggerty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed ....., 19.. Bart. P. Harrison, Registrar

APR 25 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 1922, to Apr 24 1923 that I last saw her alive on Apr 24- 1923, and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

abt (duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Man. Depres. Psychosis over (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Richmond Va.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

Apr 25 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL 4/25 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

D75189 HEALTH DEPARTMENT—CITY OF BALTIMORE 16 09 D75189

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Baby Johnson

(Residence in Baltimore: No. 1110 Ashland Ave St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	black	single

6-DATE OF BIRTH, ...4/16/23...., 1.....
(Month) (Day) (Year)

7-AGE, 2 hrs. ....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country), U

12-MAIDEN NAME OF MOTHER, Rose Johnson

13-BIRTHPLACE OF MOTHER, (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Holkins Hospital

(Address).....

15-

Filed 19.....

Robert P. Harrison,
Registrar.

25 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 16/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity - 6 to 7 months gestation
(Autopsy at Hospital)

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) J S K Collins M. D.
(Coroner.)

4/21/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL DATE OF BURIAL, ...19....

20-UNDERTAKER, Commissioner Health, ADDRESS APR 25 1923

Jas. Wm. C. WOODALL

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

Spec.—6-8-19—H. P. Co.—1000 Bks.

D75190 ✓ D75190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 X 32

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 Ausquith ST.: 5 WARD)

2-FULL NAME Marie Estelle Skipper

(a) RESIDENCE. No. 426 Ausquith ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 23, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jacksonville
(State or country) Fla.

PARENTS

10 NAME OF FATHER John Skipper

11 BIRTHPLACE OF FATHER (city or town) Dalla
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Marie Nelson

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Mother
(Address)

25 1923 Robert F. HARRISON, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1923, to April 25, 1923.

That I last saw h[illegible] alive on April 25, 1923

and that death occurred, on the date stated above, at 12 15 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil L. Haingler M. D.

April 25, 1923 (Address) 2002 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	4/27 1923

20 UNDERTAKER Mrs. A. E. Fuller ADDRESS 4806 Harford Rd

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75191

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 608 S Paca St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Lillian Di Natale

(a) Residence No... 608 S Paca St St., ... Ward...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 27/22

7-AGE. ... yrs. 10 mos. 27 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ~
(b) General nature of industry, business, or establishment in which employed (or employer) ~
(c) Name of employer

9-BIRTHPLACE (city or town) Balto
(State or Country),

PARENTS.

10-NAME OF FATHER, Alexander Di Natale

11-BIRTHPLACE OF FATHER (city or town) Italy
(State or Country),

12-MAIDEN NAME OF MOTHER, Carmela Bucci

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country),

14- (Informant) Alexander Di Natale
(Address) 608 S Paca St.

15- Filed ... 192... Robert F. Harrison, Registrar.
Burial Permit Clerk.

25 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 24-23

17- I HEREBY CERTIFY, That I attended deceased from April 21, 1923 to April 24 1923
that I last saw h[illegible] alive on April 24 1923
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Myocarditis (Acute)

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? ... Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Parran Jr M. D.
A. M., 1923 (Address) Govans Hills

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Calvary Cemetery	April 26... 1923
20-UNDERTAKER.	ADDRESS
F. A. Krause & Son	1037 Hanover St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Measles

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75192

D75192

CERTIFICATE OF DEATH.

129 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N. Dallas ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Green

(a) RESIDENCE. NO. 922 N. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Green

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caulker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Julia Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Mary Green

(Address) 922 N. Dallas St

15 Filed . 19 Robert F. [illegible] Registrar

APR 25 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22- 1923

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1923, to April 22, 1923, that I last saw him alive on April 20, 1923, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas M. D.

4-23 1923 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	April 25 1923
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75193

CERTIFICATE OF DEATH.

160

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Francis Wenger.

(a) Residence No. 2306 Winchester St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 4-23-23

7-AGE. ....yrs. ....mos. ½ ds. | If LESS than 1 day, ...hrs. or. ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John F. Wenger.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Hilda Hausman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Hospital Record

(Address)

15- Filed ..... 192. Robert P. Harrison, Registrar.

PR 25 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-23-23

17- I HEREBY CERTIFY, That I attended deceased from 4-23 1923 to 4-23 1923

that I last saw him alive on 4-18 1923

and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH* was as follows:

Laceration.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Poorly developed.

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Signs of Life

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

20-UNDERTAKER. | ADDRESS

Ernest Stanley Tulin & Sugitta

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75194

CERTIFICATE OF DEATH.

43

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Hollins ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Frederick Gundlach

(a) RESIDENCE NO. 814 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Clara Gundlach

6 DATE OF BIRTH (month, day, and year): Sept. 1, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	63	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stencil + Rubber Stamps Mfr.

(b) General nature of industry, business, or establishment in which employed (or employer): Self.

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Gundlach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cassel Germany

12 MAIDEN NAME OF MOTHER: Anna F Bruns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cassel Germany

14 Informant: Clara Gundlach

(Address) 814 Hollins St

15 Filed 25 1923 16 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 24, 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1922, to Apr. 24, 1923.

that I last saw him alive on Apr. 24, 1923,

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mouth

0

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3 - last in Jan, 1923

Was there an autopsy? no

What test confirmed diagnosis? Dr Stoddard Dr Stewart Staphs Hosp

(Signed) Emil Francke M. D.

Apr. 25, 1923 (Address) 1211 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: April 27 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75195

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75195

CERTIFICATE OF DEATH.

REGISTERED NO. 123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital, 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Bentley

(a) RESIDENCE. NO. 2227 Washington Boulevard WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John E. Bentley

6 DATE OF BIRTH (month, day, and year) Oct. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER John Henry
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md

14 Informant Ida Read
(Address) 1150 Ridgley St

15 Filed 4 25 1923 16 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-20, 1923, to 4-25, 1923 that I last saw her alive on 4-25, 1923 and that death occurred, on the date stated above, at 12-30 a.m.

The CAUSE OF DEATH* was as follows:
Gall stones
(duration) 6 yrs. mos. ds.
CONTRIBUTORY (Secondary) Obstruction of common duct
(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? Yes Date of 2-21-23
Was there an autopsy? no
What test confirmed diagnosis? Gall stones in duct
(Signed) Albert F Conroy, M. D.
, 19 (Address) Vol. of Am. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 27 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... may be ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75196

D75196

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Lancaster ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Butler

(a) RESIDENCE. NO. 1516 Lancaster ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm P Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bertha Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wm G. Butler
(Address) 516 Lancaster

15 Filed APR 25 1923 Robert P. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to April 24, 1923, that I last saw h.. alive on April 24, 1923, and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Thos D Buckler, M. D.

4/25 1923 (Address) 1623 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 26 1923
20 UNDERTAKER Wendell Dippel & Son	ADDRESS 378 N

APR 25 1923

mation should be carefully prepared, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75197 D75197

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. ii WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Young

(a) RESIDENCE No. 821 St. Paul st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rock Hill
(State or country) South Carolina

PARENTS

10 NAME OF FATHER John Young

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Anna Hutchinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Hospital Records
(Address) M.T.H.

15 Robert E. Harrison
Burial Permit Clerk Registrar

APR 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from December 28, 1922, to April 25, 1923, that I last saw her alive on April 25, 1923, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. da.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 4 mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Padgett M. D.

4-25-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hill South Carolina

DATE OF BURIAL 4/25 1923

20 UNDERTAKER Robt W Brooks & Son

ADDRESS Catherine Holland 2d

Attention should be carefully exercised that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it CAUSE OF DEATH is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75198

CERTIFICATE OF DEATH.

74-001 D75198

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 St Paul ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. T. Behn

(a) RESIDENCE NO. 2527 St Paul ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa M. Behn

6 DATE OF BIRTH (month, day, and year) July 12 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bremen Germany

PARENTS

10 NAME OF FATHER Theodore Behn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Margaret Renner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Charles H. Behn

(Address) 2527 St Paul St

15 Filed Apr 25 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 22, 1923,

that I last saw h alive on April 21, 1923,

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) several years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. Geo. Deetjen, M. D.

, 19 (Address) 1702 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Apr 26, 23
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Son	North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be entered. Avoid abbreviations. Name of disease alone insufficient. Omissions will delay burial permit. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75199

CERTIFICATE OF DEATH.

100-001 D75199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 S. Montford Ave. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Bodein

(a) RESIDENCE No. 618 S. Montford Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Bodein

6 DATE OF BIRTH (month, day, and year) May 4 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bernard Kimmerle

(Address) 618 S. Montford Ave.

15 Filed APR 26 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11 - 1923, to April 23. 1923.

that I last saw her alive on " 22 , 1923,

and that death occurred, on the date stated above, at 9 15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chas. V. Mier, M. D.

4/24/23 (address) 405 S Paca St -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	April 26 1923
20 UNDERTAKER	ADDRESS
N. Sander & Sons	1710 Fleet St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75200

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 932 S. Eutaw St. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James S. Robb. (C).

(Residence in Baltimore: No. 932 S. Eutaw St. St.; yrs. 22 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. March 7, 1879.
(Month) (Day) (Year)

7-AGE.			If LESS than 1 day,
44 yrs.	1 mos.	17 ds.	hrs. or mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): O'Do.

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER. Jacob Robb. (C).

11-BIRTHPLACE OF FATHER, (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER. Sallie Boutlits. (C)

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Musco Robb. (C) (brother).

(Address) 704 Warner Street.

15- APR 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto R. Eichardt M. D. (Coroner.)

Apr. 25, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	April 25, 1923

20-UNDERTAKER.	ADDRESS
J. L. Bramble Son	1619 N. Mount St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. — 1-10-21 — MAT — 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75201

CERTIFICATE OF DEATH.

101-001 D75201

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 527 N. Belnord Ave. ST., 7 WARD)

2-FULL NAME Julia B. Ries

(a) RESIDENCE NO. 527 N. Belnord Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of ~~the late~~ WIFE of Peter Ries

6 DATE OF BIRTH (month, day, and year) July 25 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	69	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Hornung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr Louis Ries

(Address) 527 N. Belnord Ave

15 APR 26 1923 ROBERT N. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15 1923 to April 25 1923, that I last saw h[er] alive on April 25 1923 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoselerosis

Nephritis interstitialis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Enlarged prostate

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. A. Mayer, M. D.

10-26-1923 (Address) 2436 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr. 28 1923
20 UNDERTAKER	ADDRESS
Henry Hock Son	1301 E Eager St

AGE should be stated EXACTLY. Any approximation should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Information is very important.

Spec.—1-10-21—MAT—1500 Blks.

D75202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75202

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 S High St. 3 ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Schiller

(a) RESIDENCE NO. 224 S. High ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fradel Schiller

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing 08

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto St

15 FILED APR 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17

I HEREBY CERTIFY, That I attended deceased from February, 1922, to April 25, 1923, that I last saw him alive on April 25/, 1923, and that death occurred, on the date stated above, at 11. 10 m.

The CAUSE OF DEATH* was as follows:

Cancer of intestine removed Feb. 1922 - followed by metastases to liver and elsewhere

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cancer of liver & carcinosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Feb. 1922

Was there an autopsy? No Cancer of intestine removed;

What test confirmed diagnosis?

(Signed) Frank Q. Smelz, M. D.

, 19 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale Cem	4/27/1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

REGISTRATION SHOULD BE CAREFULLY SUPPLIED. AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-002 D75203

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ..... ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Horwitz

(a) RESIDENCE NO. 510 N. Arlington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Bessie Perelis

6 DATE OF BIRTH (month, day, and year) July 3, 1897.

7 AGE 25 Years 10 Months 22 Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Buehler Bros. Baltimore

9 BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10 NAME OF FATHER Morris Horwitz

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Rachel Frankin

13 BIRTHPLACE OF MOTHER (city or town) ..... Russia (State or country)

14 Informant Mary Horwitz Epstein, (Address) Lafayette, Md.

15 Filed APR 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1923 to April 25, 1923, that I last saw him alive on April 25, 1923, and that death occurred, on the date stated above, at 7:55 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) about yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edwin B. Jones, M. D.

, 19 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rozedel

DATE OF BURIAL 4/26 1923

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Balto St

mation should be carefully supplied. Age shou... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

La Grippe

Spec.—1-10-21—M&T—1500 Blks.

D75204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75204

CERTIFICATE OF DEATH.

M00-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 896 W. Lombard St. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Barrett

(a) RESIDENCE NO. 896 W. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. W ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1st 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	W	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (City or town) Ellicott City
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Barrett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Eastern Shore Md

14 Informant Mrs. E. Lapides
(Address) 89[illegible] Hanover St

15 Filed APR 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23/23 19

17 I HEREBY CERTIFY, That I attended deceased from 4/18/23, 19.. to 7/23/23, 19..,
that I last saw her alive on 4/23/23, 19..,
and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) Thirty days yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Bernard J. Tiry, M. D.

7/5, 1923 (Address) 710 S. Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 27 19 23
20 UNDERTAKER F. B. Kefauver	ADDRESS 2335 Fulton Ave

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–12-23-21–E.B.R.S.–400 Bks.

D75205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75205

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Bevins

(a) Residence No. 1034 S. Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ? ? 1855

7-AGE. 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), ?

PARENTS.

10-NAME OF FATHER, John Haviland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ann —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14- (Informant) Hospital

(Address)

15-

APR 26 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 24 23

I HEREBY CERTIFY, That I attended deceased from April 16 1923 to April 24 1923

that I last saw h. alive on April 24 1923

and that death occurred, on the date stated above 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Thos. Legge M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem.	April 27, 1923

20-UNDERTAKER. Margaret S. Flynn ADDRESS 1422 Light St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75206

CERTIFICATE OF DEATH

101-001

D75206

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 Laurens ST., 14 WARD)

2-FULL NAME Frank J. Thomas

(a) RESIDENCE NO. 538 Laurens ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Elizabeth Thomas

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Thomas (Address) 144 N. Monroe St

15 Filed APR 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 14, 1923, to Apr 24, 1923, that I last saw him alive on Apr 23, 1923, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Lagrippe

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Paul Brown, M. D.

4/24, 1923 (Address) 1837 Bruna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Saint Peters Cemetery — DATE OF BURIAL: Apr 27 1923

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 1735 Ashland Av

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75207

REGISTERED NO. 74 D75207

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Hollins St. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel D. Ulrich

(a) RESIDENCE NO. 1235 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta L. Ulrich

6 DATE OF BIRTH (month, day, and year) Mch. 7th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) for self

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick (State or country) Md.

PARENTS

10 NAME OF FATHER George Ulrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Haller

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Md.

14 Informant Augusta L. Raabe (Address) 1235 Hollins St.

15 Filed APR 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24th 19 23

17 I HEREBY CERTIFY, That I attended deceased from April 1 1923, to April 24 1923, that I last saw him alive on April 24 1923, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis.

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Examination of urine

(Signed) [signature], M. D.

4/25 1923 (Address) 11 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 27 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St

mation should be carefully inquired. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75208

CERTIFICATE OF DEATH.

D75208

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 W. Fayette St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Murray

(a) RESIDENCE NO. 1625 W. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L. B. Murray

6 DATE OF BIRTH (month, day, and year) Dec. 8" 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant L. B. Murray

(Address) 1625 W. Fayette St.

15 APR 26 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25" 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to April 25, 1923, that I last saw her alive on April 24, 1923, and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Frank R. Ogden, M. D.

4/25 1923 (Address) 115 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynchburg Va	Apr 26 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Bond St

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75209

CERTIFICATE OF DEATH.

90 D75209

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2736 E. Balto. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wicklein

(a) RESIDENCE NO. 2736 E. Balto. ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Joseph Wicklein

6 DATE OF BIRTH (month, day, and year) Oct. 25th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Berhalter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Eastfenden (daughter)

(Address) 1911 Aisquith Street

15 Filed APR 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to April 25, 1923, that I last saw her alive on April 23, 1923, and that death occurred, on the date stated above, at 3 15/a m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. McAvoy, M. D.

4/25 1923 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	April 27, 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4038 Woodland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Fractional parts of a day, in CASES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D75210

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 Jefferson ST., 6 WARD)

2-FULL NAME Rita Frances Volpe

(a) RESIDENCE NO. 2024 Jefferson ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 18 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Carmello Volpe

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mollie Serani

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Carmello Volpe (Father)
(Address) 2024 Jefferson St.

15 FILED APR 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to April 24, 1923,

that I last saw her alive on April 24, 1923,

and that death occurred, on the date stated above, at 9 a/ m.

The CAUSE OF DEATH* was as follows:

Whooping - Cough

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Broncho - Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Joan M. Krauter, M. D.

, 19 (Address) 735 S. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	April 26 1923
20 UNDERTAKER	ADDRESS
Lilly - Zeiler	403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. Erasures, interlineations, or illegible words CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75211

CERTIFICATE OF DEATH.

D75211

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 N Stricker ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Watts

(a) RESIDENCE NO. 313 N Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

AGE should be stated EXACTLY. FRACTIONS of a year or month should be reduced to days, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 53; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lucy Brown

(Address): P. Expo. nd

15 FILED APR 26 1923 ROBERT H. KRAUTER, Register

Burial Permit Clerk David Easton

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23rd 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1923, to April 23, 1923, that I last saw h alive on April 23, 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Unknown (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Articular Rheumatism

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

April 26, 1923 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery, Baltimore Co. Md.

UNDERTAKER

DATE OF BURIAL: 4-26-1923

ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Blks.

D75212

HEALTH DEPARTMENT—CITY OF BALTIMORE

108 D75212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Vincents Infant Asylum

CITY OF BALTIMORE: (No. 1401 Division ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Faddis

(a) RESIDENCE NO. 1401 Division ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 8-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Sister Faddis (Address) 1401 Division St.

15 Filed APR 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to April 25, 1923, that I last saw her alive on April 24, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Catarrhal Stomatitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A. F. Ingram M. D.

, 19 (Address) 2439 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apr. 26 1923

20 UNDERTAKER George L. Schwartz ADDRESS Frederick, Md.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D75213

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. D75213

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Kirby Sombrill

(a) RESIDENCE NO. 1321 Linden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. L. J. Sombrill.

6 DATE OF BIRTH (month, day, and year) May 28 1873.

7 AGE 50 Years Months 28 Days (If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm L. Kirby

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Marion Hoore

13 BIRTHPLACE OF MOTHER (city or town) Balto Co, Md
(State or country)

14 Informant Chas L.D. Sombrill (husband)
(Address) 1321 Linden ave.

15 Filed APR 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1923, to April 25, 1923, that I last saw h alive on April 25, 1923, and that death occurred, on the date stated above, at 7:05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast
Metastasis to liver

(duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin A. Jarrett M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL April 27 1923

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. Any informant may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75214

CERTIFICATE OF DEATH.

90

REGISTERED NO. D75214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1339 Mt Royal Ave (Ward) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D Levine

(a) RESIDENCE. No. 506 N. Calvert St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 8 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer): Bath House

(c) Name of employer: Water Dept

9 BIRTHPLACE (city or town) (State or country): County Longford Ireland

PARENTS

10 NAME OF FATHER: James Devine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Longford Ireland

12 MAIDEN NAME OF MOTHER: Mary Molligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Longford Ireland

14 Informant (Address): Mrs Elizabeth Dunn 1339 Mt Royal Ave

15 APR 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24th 1923. to April 25th 1923. that I last saw him alive on April 25th 1923. and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Haemoptysis

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Valvular heart disease

(duration) 2 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? Clinical & Physical

(Signed) Wm Hammann, M. D.

4/26 1923 (Address) 1701 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	4/27 1923
20 UNDERTAKER	ADDRESS 3000 E Baltimore
J. A. Moran	

INFORMATION should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75215

CERTIFICATE OF DEATH.

D75215

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Eutaw Place | 4 WARD)

2-FULL NAME Mary Connor

(a) RESIDENCE NO. 1407 Eutaw Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Connor

6 DATE OF BIRTH (month, day, and year) Oct 14 53

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	6	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS
10 NAME OF FATHER John Shroh
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Werner
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Wm A Connor
(Address) 1407 Eutaw Place

15 FILED APR 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from September, 1922, to April, 1923, that I last saw h— alive on April 25, 1923, and that death occurred, on the date stated above, at 11:45 p. m.

The CAUSE OF DEATH* was as follows:

Lympho-Sarcoma

(duration) ... yrs. 10 mos ... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...
Did an operation precede death? — Date of ...
Was there an autopsy? —
What test confirmed diagnosis? ...

(Signed) H. J. Thurn, M. D.
4-26-1923 (Address) 801 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City	April 28 1923
20 UNDERTAKER W. M. Rountree	ADDRESS 2238 N Howard

mation should be carefully supplied. AGE should be stated EXACTLY. Physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Groin - first organ involved

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75216 CERTIFICATE OF DEATH. 5 100-001 D75216

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Kelly

(a) Residence No. 1004 ~~22~~ Necessity Alley St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1857 ?

7-AGE. 65 ? yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.
10-NAME OF FATHER, James Kelly
11-BIRTHPLACE OF FATHER (city or town) (State or Country). ?
12-MAIDEN NAME OF MOTHER, ?
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Municipal Hospital Records
(Address) .....

Filed APR 26 1923 192.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk. THE MORGUE.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 12, 19 23 to April 18, 19 23
that I last saw him alive on April 18 19 23
and that death occurred, on the date stated above, at 6:15 A. M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
.....
.....
.....
(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) J. A. McKay M. D.
4-18-. 19 23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND — DATE OF BURIAL. APR 25 1923

20-UNDERTAKER. Commissioner Health, — ADDRESS .....

Per. Wm. E. WOODALL.

Should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75217

CERTIFICATE OF DEATH.

44 D75217

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4192 Belair Road ST., Rosebury WARD)

(MOBLEY)

2-FULL NAME Myra H. Mobley

(a) RESIDENCE NO. Frederick Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James C. Mobley

6 DATE OF BIRTH (month, day, and year) Feb. 25th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Martinsburg (State or country) West Virginia

PARENTS

10 NAME OF FATHER John Dickens

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Charles Steward

(Address) 4192 Belair Road

15 Robert F. HARRISON, Registrar

APR 26 1923 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to April 24, 1923, that I last saw h alive on April 24, 1923, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl Jones, M. D.

4/26/1923 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery Frederick Md	April 27 23
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75218

CERTIFICATE OF DEATH.

12 D75218

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Southern Ave. ST., Govanville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A. Miller

(a) RESIDENCE No. 18 Southern Ave. ST., Govanville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Miller

6 DATE OF BIRTH (month, day, and year) Oct. 28th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER John Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Driscoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mamie Miller (Address) 18 Southern Ave Govanville

15 Filed APR 26 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to April 25, 1923, that I last saw h alive on April 25, 1923, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Pulmonary Oedema.

(duration) yrs. mos. ds.

Infected Gall Bladder & Pancreatitis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? yes Date of Unknown

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) C. Carroll Jones, M. D.

April 26, 1923 (Address) 4 W. Hamilton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL April 30, 23

20 UNDERTAKER Fred'k Lassahn & Sons

ADDRESS Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75219

D75219

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Homestead st ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George C Anders.

(Residence in Baltimore: No. 616 Homestead st St.; yrs. One hour mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Infant

6-DATE OF BIRTH. April 26, 1923 (Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. One hour ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). 616 Homestead st

PARENTS.

10-NAME OF FATHER. George C Anders

11-BIRTHPLACE OF FATHER (State or Country). Baltimore md

12-MAIDEN NAME OF MOTHER. Mildred M Lantta

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George C Anders

(Address) 616 Homestead St

15- Filed ..... 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 26, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 26 1045 am 1923, to April 26 1145 1923, that I saw h[illegible] alive on April 26 1923, and that death occurred, on the date stated above, at 1145 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

at 6 1/2 & 7 months

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Weakness

(Duration) ..... yrs. One hour mos. ..... ds.

(Signed) Hermann Muttrock M. D.

April 26, 1923 (Address) 616 Gusdorf ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery. DATE OF BURIAL, April 28, 1923

20-UNDERTAKER Wm Ips Sons & Teufel & Son ADDRESS 801 W Fayette St

No. 26 1923

Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D75220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75220

CERTIFICATE OF DEATH.

65-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Hugo ave' ST., 9 WARD)

2-FULL NAME Caroline Bohnet

(a) RESIDENCE NO. 2700 Hugo ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of of John Bohnet

6 DATE OF BIRTH (month, day, and year) Nov 30/1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Germany

PARENTS

10 NAME OF FATHER George Behn

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Behn

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant John Bohnet (Address) 2700 Hugo av

15 Filed APR 26 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2 1923, to April 24 1923,

that I last saw her alive on April 24 1923,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkin's disease

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Hypertrophic Pulmonary

(duration) yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. H. A. Mayer, M. D.

4.24. 19 23 (Address) 2438 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL April 28 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1737 Harford ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75221

CERTIFICATE OF DEATH.

99-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Aisquith ST., 5 WARD)

2-FULL NAME Zelda Shlein

(a) RESIDENCE NO. 115 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 yrs	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant L. Wolman (Address) 16 Virginia Ave.

15 Filed APR 26 1923, 19 Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 21st, 1923, to April 26th, 1923.

that I last saw her alive on April 25, 1923

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Lehman, M. D.

4-26 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Mt Carmel

DATE OF BURIAL April 27 1923

20 UNDERTAKER Max Lerman

ADDRESS 1217 E Baltimore

AGE should be carefully supplied. AGE should be stated EXACTLY. Fractions of a year should be stated in terms of days. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75222

182 D75222

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Lancaster St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Karl Krudsen

(Residence in Baltimore: No. Unknown St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Unknown

6-DATE OF BIRTH. Unknown, 1 (Month) (Day) (Year)

7-AGE. about 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr 22nd 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest on the (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, aut (Inquest, autopsy or Inquiry.) find that said deceased came to h death on the day stated above.

THE CAUSE OF DEATH* was as follows: Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry P. Norton M. D. Coroner

Apr 26 1923 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

APR 26 1923

THE MORGUE

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly certificated. This is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75223 90 D75223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital St., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Williams

(a) RESIDENCE NO. 1619 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roberta G. Thomas

6 DATE OF BIRTH (month, day, and year) 2-6-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER George A. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Rosa Sherwood 1617 Druid Hill Ave.

15 Filed 19 Robert P. Harrison, Registrar

26 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-1923

17

I HEREBY CERTIFY, That I attended deceased from 4-17, 1923, to 4-25, 1923, that I last saw h in alive on 4-20, 1923, and that death occurred, on the date stated above, at 4:40 p. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease

(duration) Probably yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no.

What test confirmed diagnosis? -

(Signed) George C. Page, M. D.

19 (Address) 1700 N. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemty	April 27, 23
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75224 ✓ D75224

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 515 Robert ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James M. Allen

(a) RESIDENCE NO. 515 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paperhanger

(b) General nature of industry, business, or establishment in which employed (or employer) 53

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah L. Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Frances P. Allen

(Address) 515 Robert Street

Filed APR 26 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 26th, 19 23, to April 26th, 19 23, that I last saw h[illegible] alive on April 26th, 19 23, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Val. Dis. of heart, (Mitral)

Caused by Extreme Nervousness

Exhaustion

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion Fractured

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) D. Steele, M. D.

19 (Address) 607 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemty	April 29 23

20 UNDERTAKER	ADDRESS
Geo. J. A. Gibson	513 Laurens

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75225

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 Vine ST., 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Schwartz

(a) RESIDENCE No. 2106 Vine ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Schwartz

6 DATE OF BIRTH (month, day, and year) May 20 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	71	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Adolph Schwartz

(Address) 1754 Patapsco

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk

R 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to April 24, 1923, that I last saw h[illegible] alive on April 23, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Epharactane (duration) yrs. mos 7 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Signed R. L. Campbell, M. D.

April 24, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	April 28 1923
20 UNDERTAKER	ADDRESS
F. A. Tranert Son	[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is required to fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75226 ✓ D75226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 E 23d ST., 9 WARD)

2-FULL NAME William J Cochran

(a) RESIDENCE NO. 540 E 23d ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Cochran

6 DATE OF BIRTH (month, day, and year) March 14 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co

PARENTS

10 NAME OF FATHER Daniel Cochran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary C. Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary J. Cochran (Address) 540 E 23rd St

15 Filed ..... 19 ..... Registrar

PR 26 1923 Robert F. HARRISON, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/22 , 1923 , to 4/24 , 1923 .

that I last saw h alive on 4/24 , 1923 ,

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? —

(Signed) Dr Bernard Wells, M. D.

4/25 1923 (Address) 914 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St John Lem Long Green	April 27 1923
20 UNDERTAKER	ADDRESS
C. A. Wiedefeld	501 E 22nd St

B—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful in giving information. AGE should be stated EXACTLY. PHYSICIAN should be careful in stating CAUSE OF DEATH. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D75227

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH
D75227

County ..... Registration Dist. No. .....

Village or City Baltimore (No. 16 Fairly Ave) St. (Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Christiana Frey 35 years
Edward & Fairley Ave

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: May 6th, 1847 (Month) (Day) (Year)

7 AGE: 76 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Not Known
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9 BIRTHPLACE (State or country): Not Known

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Nagle
(Address) Edward & Fairley Ave

15 Filed ... 191 ... Registrar
Robert P. Harrison,

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr 25 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 16 1923 to Apr 25 1923
that I last saw her alive on Apr 20 1923
and that death occurred on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Old age

Dysentery (Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) Wm D Cooper M. D.
4/26 1923 (Address) Cor. E & Fairley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL: Western Cemet
DATE OF BURIAL: 4/27 1923

20 UNDERTAKER: J Lenser & Bro
ADDRESS: 112 E Balto st

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting Form No. 1.

NO. 26 1923

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75228

CERTIFICATE OF DEATH.

74-001 ✓ D75228

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 2779 Almeada Blvd ST., 9 WARD)

2-FULL NAME Peter C. M. Lampe,

(a) RESIDENCE NO. 2779 Almeada Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Anna Marie Lampe,

6 DATE OF BIRTH (month, day, and year) Nov 2, 1845?

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Designer

(b) General nature of industry, business, or establishment in which employed (or employer) of China Ware

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10 NAME OF FATHER Peter Lampe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Margaret Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant (Address) Mrs Anna M. Lampe 2779 Almeada Blvd

15 Filed APR 26 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl. 14th 1923, to Apl 25th 1923.

that I last saw h. alive on Apl 25th 1923 and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorhage.

(duration) yrs. 10 mos — ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert S. Kirk, M. D.

(Address) 3126 Hereford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 28 1923
20 UNDERTAKER Jos Joerdens & Son	ADDRESS 277 S. Paca

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75229

D75229

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. On way from Lexington + Park Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frank H. Dunkle

(Residence in Baltimore: No. Rennert Hotel St.; yrs., ... mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. June (Month) 12th (Day) 1876 (Year)

7-AGE. 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Owner of
(b) General nature of Industry, business, or establishment in which employed (or employer). Laundry

9-BIRTHPLACE. (State or Country). Va.

PARENTS.

10-NAME OF FATHER. W. Dunkle

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Alice Stokes

13-BIRTHPLACE OF MOTHER. (State or Country). ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Dunkle

(Address) Winston Salem

15- APR 27 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 26 (Day) 23 (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Dur. Few days Acid Accidents (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Apr. 26. 1923. (Address) 768 Cherry (Coroner)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence. North Carolina

19-PLACE OF BURIAL OR REMOVAL, Winston Salem, N.C. DATE OF BURIAL, 4/27/ 19.23

20-UNDERTAKER. E J Hanning & Son ADDRESS 1936 Lafayette Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

163211
D75230

90 D75230

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St.. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Muller

(a) RESIDENCE No. Raspeburg St. WARD Md. (Mayo Ave.)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred under 1 mos. ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Paul Muller

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed APR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to April 25, 1923

that I last saw h alive on April 25, 1923

and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Hypotension, chronic myocarditis myocardial insufficiency, annular fibrillation

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. W. Cummings M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL April 28 1923

20 UNDERTAKER Wm Corle — ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH CARE AND PENCIL. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION on back of certificates. See instructions on back o TION is very important.

Spec—12-23-21—E.B.R.S.—400 Exs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75231

D75231

CERTIFICATE OF DEATH.

90

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John O. Hamilton

(a) Residence No. 209 N. Madison St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 5 1863

7-AGE. 50 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Editor.

(b) General nature of Indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Penna

PARENTS.

10-NAME OF FATHER, Alfred Hamilton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Catherine Boulinger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14- (Informant) Mr Bennett

(Address) 209 W Madison St

15- Filed APR 27 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-26-23

17- I HEREBY CERTIFY, That I attended deceased from 4-23 1923 to 4-26 1923

that I last saw h... alive on 4-25 1923

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dropsy-

ensalon (Duration) yrs. mos. 3 ds.

*18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr Legg

(Signed) J. J. Chambers M. D.

19 (Address) Mercy Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, April 28 1923

St Lukes Cem Germantown Pa

20-UNDERTAKER. ADDRESS

Geo. A. Perkins Sons Co 1 Lexington St

Certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75232 ✓ D75232

D75232

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1714 Holbrook ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Power

(a) RESIDENCE. No. 1714 Holbrook ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 17 23

7 AGE — Years: — Months: 1 — Days: 9 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER John Power

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Catherine Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Timothy Murphy (Address) 1714 Holbrook St

15 Filed AUG 27 1923, 19 RUSSELL R. KRAUER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to April 26, 1923, that I last saw him alive on April 26, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. H. Magness, M. D.

4-26 1923 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Cross Harford Apl 27 1923

20 UNDERTAKER — ADDRESS

Wm Cook 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stoc—12-23-21—E.B.R.S.—400 Bks.

D75233 HEALTH DEPARTMENT—CITY OF BALTIMORE D75233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 608 S. Paca St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonina Di Natale

(a) Residence No. 608 S. Paca St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) —

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 27/22

7-AGE, ~~10~~ 10 yrs. 29 mos. 29 ds.
If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto
(State or Country),

PARENTS.

10-NAME OF FATHER, Alex Di Natali

11-BIRTHPLACE OF FATHER (city or town) Italy
(State or Country),

12-MAIDEN NAME OF MOTHER, Carmela Bruno

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country),

11- (Informant) Alex Di Natali
(Address) 608 S. Paca St

13- Filed APR 27 1923 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 22 1923 to April 26, 1923
that I last saw her alive on April 26, 1923
and that death occurred, on the date stated above, at 7.30 a.m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death? No Date of.....
Was there an autopsy? No
What test confirmed diagnosis?.....

(Signed) E. L. Peerman M. D.
4. 26., 1923 (Address) Ten Hills

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mem. Cathedral Cem.	April 27, 1923
20-UNDERTAKER,	ADDRESS
F. A. Krause & Son	713 Hanover St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D75234

CERTIFICATE OF DEATH

1794 D75234

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3412 Duvall Ave St.: 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Frances Dump

(Residence in Baltimore: No. 3412 Duvall Ave St.: ..... yrs. ..... mos. ..... ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widow

6 DATE OF BIRTH: August (Month) 23, (Day) 1841 (Year)

7 AGE: 81 yrs. 8 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Scott Hughes

11 BIRTHPLACE OF FATHER (State or country): Harford Co Md.

12 MAIDEN NAME OF MOTHER: Rebecca Knapp.

13 BIRTHPLACE OF MOTHER (State or country): Harford Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ella Hynes
(Address) 3412 Duvall Ave

15 Filed APR 27 1923 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr. (Month) 25 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1922, to Apr. 25 1923, that I saw h er alive on Apr. 25, 1923, and that death occurred, on the date stated above, at 3.40 A m.
The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Lewis W Cashman Jr. M. D.
Apr. 25, 1923 (Address) 1505 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 4/27/23, 191

20 UNDERTAKER: H E Hughes — ADDRESS: 424 N. Broadway

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75235

CERTIFICATE OF DEATH.

4/D75235

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 370 2 N. Charles ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E Baynes

(Residence in Baltimore: No. 370 N Charles St) St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, November (Month) 14 (Day), 1839 (Year)

7-AGE, 83 yrs. 5 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Back Md

PARENTS.

10-NAME OF FATHER, William Seymour

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Sarah A. Waltham

13-BIRTHPLACE OF MOTHER (State or Country), Kent Island Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Daniel MacLea

(Address) 370 N Charles St Balto

15- APR 27 1923 Filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 25 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1921, to April 25 1923, that I saw h.s alive on April 24 1923, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows: Calcumous of the Stomach

Sept 1921 Bronchopneumonia

Carcinoma (Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (Duration) yrs. mos. ds.

(Signed) Geo. L McShane M. D.

April 27, 1923 (Address) 2346 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, 4/28/23 191...

20-UNDERTAKER N E Hughes

ADDRESS 4st N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be carefully ascertained and properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1 10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75236

CERTIFICATE OF DEATH.

154-002 D75236

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 W. 40th St ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm E Naylor

(a) RESIDENCE NO. 1106 W 40th St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Auther M Naylor

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary L Lewis

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Auther M Naylor (Address) 1106 W 40th St

15 Filed APR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-16-, 1923 to 4-26, 1923 that I last saw h.. alive on 4-26, 1923 and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Potts Tarana Oral

(duration) yrs. 3 mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Path of Exam

(Signed) [illegible] M. D.

4-27 1923 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Apr 28 1923
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut ave

Spec.—1-10-21—M&T—1500 Blks.

Wilkes

HEALTH DEPARTMENT—CITY OF BALTIMORE D75237

D75237

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Mosher St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George William Shea

(a) RESIDENCE NO. 625 Mosher St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Francis Wilkes

6 DATE OF BIRTH (month, day, and year) Dec. 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ... min.
65	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Toronto Canada

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ada M. Smith (Address) 1111 W. Lanvale St.

15 Filed APR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24th 1923. to April 26th 1923.

that I last saw him alive on April 26th 1923.

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 72 W. Mt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	4/29 1923
20 UNDERTAKER Samuel T. Hensley	ADDRESS 528 N. Eutaw St.

N. B.—WHITE BURIAL, WHITE CREMATION and WHITE REMOVAL PERMITS will be issued only upon information which should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75238 D75238

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Johnson

(a) RESIDENCE No. 526 N. Pine st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 FILED APR 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to April 24, 1923, that I last saw him alive on April 24, 1923, and that death occurred, on the date stated above, at 12.35 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 8 ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumothorax (spontaneous)

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglacca M. D.

4-24-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Antrim Cem. DATE OF BURIAL 4-27-23

20 UNDERTAKER Samuel Kemsley ADDRESS Baldwin

N. B.—WHITE PAPER, WITH CANARY BORDER. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75239 — 27 — D75239

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Pappleton St.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Neal

(Residence in Baltimore: No. 309 Pappleton St.; 46 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Un Known ....., 187[illegible]
(Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 31

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Louis Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Un Known

13-BIRTHPLACE OF MOTHER (State or Country), Un Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Neal

(Address) 309 Pappleton

15- Filed APR 27 1923 191... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1923, to April 24 1923, that I saw her alive on April 22 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Renal Insufficiency

(Duration) yrs. 5 mos. ds.

(Signed) H. S. McCard M. D.

4/25, 1923 (Address) 2005 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 4/27/23

20-UNDERTAKER Samuel Bleunday

ADDRESS 578 Eddy St

Spec.-12-23-21-E.B.R.R.-400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75240

CERTIFICATE OF DEATH.

90 D75240

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary King

(a) Residence No. 1141 Par[illegible] Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1851

7-AGE.	If LESS than 1 day,
72 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

11- (Informant) Municipal Hospital Records

(Address)

13- Filed APR 27 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 25, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 6, 1918, to April 25, 1923, that I last saw her alive on April 25, 1923, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & heart failure

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Obesity & hypertension

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. McKay M. D

4-26- 1923 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn	4/28/23
20-UNDERTAKER. Samuel T Kemsley & Ed Lidell	ADDRESS 538

NOTE—Cause of death should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75241

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75241

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salem Yancy

(a) Residence No. 1519 Pressman St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1879

7-AGE.	If LESS than 1 day.
43 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) N/D

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, Not known?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). South Carolina

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). South Carolina

11- (Informant) Municipal Hospital Record

(Address)

Filed APR 27 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 24, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 23 1923 to April 24 1923.

that I last saw him alive on April 24 1923.

and that death occurred, on the date stated above, at 11:35 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes autopsy

What test confirmed diagnosis?

(Signed) J. A. McKay M. D

4-25- 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Laurel	April 27 1923
20-UNDERTAKER Thos. H. Lewis	ADDRESS 143 Greenmount

Hand

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75242 HEALTH DEPARTMENT—CITY OF BALTIMORE D75242

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1435 N Mount ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John William Walker Weems

(a) RESIDENCE No. 1435 N Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jones

6 DATE OF BIRTH (month, day, and year) Dec 30 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	40	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General work

(c) Name of employer at Large

9 BIRTHPLACE (city or town) Charlotte Hall (State or country) St Mary's Co Md.

PARENTS

10 NAME OF FATHER John H. Weems

11 BIRTHPLACE OF FATHER (city or town) Charlotte Hall (State or country) St Mary Co Md

12 MAIDEN NAME OF MOTHER Mary Wallis

13 BIRTHPLACE OF MOTHER (city or town) Charles Co. Md.

14 Informant Grace Barber (Address) 1435 N Mount St.

15 Filed APR 27 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1923

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 25, 1923, that I last saw h.. alive on April 24, 1923, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

4/25, 1923 (Signed) Bernard S French, M. D. (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlotte Hall Md.

DATE OF BURIAL April 27 1923

20 UNDERTAKER James N. Dennis

ADDRESS 1203 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

D75243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75243

CERTIFICATE OF DEATH.

127

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 18 WARD)

2-FULL NAME Mrs. Bessie Shevitz

(a) RESIDENCE NO. 433 N. Carey Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 18 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Shevitz

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sam Rochkind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rae Koon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1427 E Baltimore

15 Filed APR 27 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to April 26, 1923, that I last saw her alive on April 26, 1923, and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure or insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pancreatitis Acute

(duration) yrs. mos. 2 ½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 4/25/23 exploration + closure of abdomen

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. Bailer Strassheimer, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 4/27 1923

20 UNDERTAKER Jack Lewis 1439 E Baltimore

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75244 HEALTH DEPARTMENT—CITY OF BALTIMORE D75244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1st Brew Troop K

CITY OF BALTIMORE: (No. Mowumental & Cullen Sts ST., 6 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Rudo

(a) RESIDENCE NO. 31 N. Montford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Rudo

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1139 E Baltimore St

15 Filed APR 27 1923, 19 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/24/23, 19 23, to 4/26, 19 23,

that I last saw h[illegible] alive on 4/26, 19 23,

and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia Lobular

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4/23/23

Was there an autopsy? Yes

What test confirmed diagnosis? Gross Lesions

(Signed) Isador Rothschild, M. D.

, 19 (Address) Hebrew Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 4/27 1923

20 UNDERTAKER Jack Lewis 1139 E Balto St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75245

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 D75245

REGISTERED NO. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1020 Mc Donough St. 7 WARD)

2-FULL NAME Suzzetta Dorothea Schmidt

(Residence in Baltimore: No. 1020 Mc Donough St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word) Single

6-DATE OF BIRTH July (Month) 8 (Day), 1922 (Year)

7-AGE ..... yrs. 9 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Balto

PARENTS

10-NAME OF FATHER Geo R Schmidt

11-BIRTHPLACE OF FATHER (State or country) Baltimore

12-MAIDEN NAME OF MOTHER Bertha Hauck

13-BIRTHPLACE OF MOTHER (State or country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George R Schmidt

(Address) 1020 Mc Donough St

15 APR 27 1923 Filed ..... 191 ROBERT R. KRAUTER, REGISTRAR Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April 24th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 21st, 1923, to April 24th 1923, that I saw h[illegible] alive on April 24th, 1923, and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:

Measles

(Duration) ..... yrs. ..... mos. 5 ds

Contributory (SECONDARY) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) P E Silly M. D.

April 26th, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Baltimore Cemetery

DATE OF BURIAL April 27, 1923

20-UNDERTAKER John Sullivan

ADDRESS 2008 Eutaw

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75246

CERTIFICATE OF DEATH.

D75246

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—(No. 502 N. Eutaw ST., 10 WARD)

2-FULL NAME Estella Worsham

(a) RESIDENCE No. 502 N. Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1917

7 AGE Years 5 Months 8 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert Worsham

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Elizabeth Chairman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Robert Worsham 502 Eutaw St.

15 APR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/22, 1923, to 4/26, 1923, that I last saw her alive on April 26, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

"Scarlatina"

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

(Address) 1520 E Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Luray, Shenandoah Co Va — DATE OF BURIAL: Apr 28/23

20 UNDERTAKER: W. M. Cook — ADDRESS: 501 E Baltimore St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 +/00-001 D75247

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registered No.

2-FULL NAME Cecil Hamilton

(a) Residence No. Aberdeen Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 27 1913

7-AGE. 9 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Mary Land

PARENTS.

10-NAME OF FATHER, George H. Hamilton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Mary Land

12-MAIDEN NAME OF MOTHER, Cornelia James

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Mary Land

14- (Informant) Evelyn Hamilton

(Address) Aberdeen Md.

15- Filed APR 27 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 26 1923

17- I HEREBY CERTIFY, That I attended deceased from 4-19, 1923 to 4-26, 1923

that I last saw him alive on 4-26, 1923

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Pneumonia)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Empyema & Cardiac Failure (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Empyema

(Signed) J. Bonaparte M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md. DATE OF BURIAL: 4/27/23

20-UNDERTAKER: W. J. Tubman & Son ADDRESS: Park Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓

D75248

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tacy Johnson

(a) RESIDENCE NO. 517 Hargrove Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard Johnson

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.C.H.

15 Filed APR 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1923, to April 23, 1923, that I last saw her alive on April 23, 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? TB in sputum, X-ray

(Signed) Francis L. Sadoglinicco M. D.

4-23-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL April 27, 1923

20 UNDERTAKER Wm Robert A. Elliott — ADDRESS 1725 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D75249

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1033 N. Wolfe St ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Johnson

(a) RESIDENCE. No. 1033 N. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Johnson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tuber

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nellie Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Fredrick Stetson (Address) 1033 N. Wolfe St

15 Filed APR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10 1923, to April 24, 1923, that I last saw h~~im~~ alive on April 23, 1923 and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E Thomas, M. D.

4-25 1923 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Lawn Cemetery Md	Apl 27 1923
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75250

CERTIFICATE OF DEATH.

51 D75250

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Keyser ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Denby

(a) RESIDENCE. No. 2023 Keyser ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 55 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Denby

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years 55 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Heneman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Henry Denby

(Address) 2023 Keyser St

15 APR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1923, to Apr 24, 1923,

that I last saw h[illegible] alive on Apr 24 23,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) R. Gardner Schmidt M. D.

(Address) 1534 - Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon cemetery

DATE OF BURIAL: April 27 1923

20 UNDERTAKER: Edward Bryson

ADDRESS: 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75251

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001 D75251

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1125 Madison Av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bessie Viola Hawkins

(Residence in Baltimore: No. 508 E. 29 St.; ..... St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April (Month) 26 (Day), 1923 (Year)

7 AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 12 hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Harry L. Hawkins

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Kathrin Baust

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M. Alice O'Toole

(Address) 1125 Madison Av

15 Filed APR 27 1923, 191 ROBERT K. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 27 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1923, to April 27 1923, that I saw h[illegible] alive on April 27, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Hobart Keech M. D.

April 27, 1923 (Address) 219 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: [redacted] DATE OF BURIAL .....

20 UNDERTAKER: Wm. M. Genthoff ADDRESS 2839 Rayne

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec. 1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75252 ✓ D75252

CERTIFICATE OF DEATH.

128

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Boys Seamens Home ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J Blair

(a) RESIDENCE NO. 417 Hollins St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of, (or) WIFE of Fredericka Dacker Blair

6 DATE OF BIRTH (month, day, and year) Sept 25 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 880

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William F Blair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Bertha M Zimmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Mrs Fredericka Blair
(Address) 417 Hollins St.

15 APR 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to April 25, 1923.

that I last saw h.. alive on " 24, 1923,

and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(over)

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw F Cockahan M. D.

4/26, 1923 (Address) 24 N Dueton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	4/28 1923
20 UNDERTAKER	ADDRESS
Geo J Cowan & Son	901 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can bo ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75253

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... Municipal Tuberculosis Hospital ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lombard Carter

(a) RESIDENCE NO. 1010 N. Carlton st. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) May 29-78 [redacted] ? -

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Unknown

(c) Name of employer ..... Unknown

9 BIRTHPLACE (city or town) (State or country) ~~Maryland~~ Va

PARENTS

10 NAME OF FATHER Moses Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Maryland~~ Va

12 MAIDEN NAME OF MOTHER Eliza Wright Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Maryland~~ Va

14 Informant (Address) Hospital Records M.C.H.

15 Filed APR 24 1923 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 23, 1923, that I last saw him alive on April 23, 1923, and that death occurred, on the date stated above, at 10.30 p. m.

The CAUSE OF DEATH* was as follows:

Aneurysm (syphilitic)

(duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy, x-ray

(Signed) Francis L. Dadaglianca M. D.

4-24-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Balto. | DATE OF BURIAL 4-27-1923

20 UNDERTAKER Samuel H. Grace & Son | ADDRESS 1400 Mosher

Spec. F 10-21 M&T 1500 Blks.

D75254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75254

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 E. Chapel ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Register

(a) RESIDENCE NO. 1711 E. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 10 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Register

6 DATE OF BIRTH (month, day, and year) May 28. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	37	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police 61

(b) General nature of industry, business, or estshlishment in which employed (or employer) City

(c) Name of employer Park Board.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel Register

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Register

(Address) 1711 E. Chapel St

15 Filed APR 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26. 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 27. 1922. to Apr 26. 1923.

that I last saw h.. alive on Apr 26. 1923

and that death occurred, on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Nephritis.

(duration) yrs. 6. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. N. Meyer Jr. M. D.

4/26. 1923 (Address) 2638 E Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	April 26. 1923
20 UNDERTAKER	ADDRESS
Hopkins & Pearson	So. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75255 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75255

CERTIFICATE OF DEATH. 182

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE, (No. Foot of Clinton St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frank Adamski

(Residence in Baltimore: No. 626 So. Montford Ave St.; 16 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Oct (Month) 13th (Day) 1887 (Year)

7-AGE. 33 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Paul Adamski

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Mary Wastavitch

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Adamski

(Address) 626 So. Montford ave

15- APR 27 1923 Filed ..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 25th (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Morton M. D. (Coroner.)

Apr 26 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary — DATE OF BURIAL. April 28 1923

20-UNDERTAKER. John Weber — ADDRESS 1803 Bank St

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75256

CERTIFICATE OF DEATH.

164 D75256

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1717 N. Mountford ST.; 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dennis K Bradley

(Residence in Baltimore: No. 1717 N. Mountford St.; 20 yrs. ..... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Married

6-DATE OF BIRTH June 1, 1888
(Month) (Day) (Year)

7-AGE, 34 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Army
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Dennis Bradley

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Ann Kane

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Bradley

(Address) 1717 N. Mountford

15- Filed APR 27 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 25th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20th 1923, to April 25th 1923, that I saw h[illegible] alive on April 25th 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(b) .....

(c) .....

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm M Wright M. D.

April 27 1923 (Address) 1801 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Johns Cemetery	Apl 28 1923

20-UNDERTAKER Clark & Tennyson ADDRESS [illegible]

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75257

CERTIFICATE OF DEATH.

99-002 D75257

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2032 Jefferson ST., 7 WARD)

2-FULL NAME Sarah C Kellenbeck

(a) RESIDENCE NO. 2032 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of VOCATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joseph T Kellenbeck

6 DATE OF BIRTH (month, day, and year) July 23 1838

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Wm Bradeyhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Wm Kellenbeck (Address) 3309 Colgate St.

15 FILED APR 27 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to April 25, 1923, that I last saw her alive on Apr. 25, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Senile Broncohood.

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy Examination

(Signed) Jno Edw Thos Blades M. D.

(Address) 1437 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 28 1923.

20 UNDERTAKER Robt J Turner Inc

ADDRESS 1442 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

D75258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D75258

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 Baker ST., 14 WARD)

2-FULL NAME Owen Johnson

(a) RESIDENCE NO. 538 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colard	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 - 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Charles Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jennie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Jennie Johnson

(Address) 538 Baker

15 APR 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1923

17

I HEREBY CERTIFY, That I attended deceased from 4/13, 1923, to 4/26, 1923, that I last saw him alive on 4/26, 1923, and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bruce Roberts, M. D.

4/26, 1923 (Address) 2134 Dill Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mila Va DATE OF BURIAL April 28 1923

20 UNDERTAKER Robert Williams ADDRESS 1515 McElderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75259

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gross #2

(a) RESIDENCE. No..... ST..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Cook.

(c) Name of employer

9 BIRTHPLACE (city or town) Washington Co; Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant [illegible] Surveyor Warden
(Address) Robert J. Harrison

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

THE MORGUE.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17

I HEREBY CERTIFY, That I attended deceased from December 22, 1921, to April 20, 1923,

that I last saw him alive on April 20 1923,

and that death occurred, on the date stated above, at 8.05 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure - myocarditis - Cystitis - Arteriosclerosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) William R. Schwartz, M. D.

4/21, 1923 (Address) Maryland Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 23

M. W. E. WOODALL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75260

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Ober Fertilizing Works. Hull St. 22 90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Wilson. (C). 5 ----------.

(Residence in Baltimore: No. 707 Hanover St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
45 yrs. ---- mos. -- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Sumpton S.C.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Kenard. (C).

(Address) 707 Hanover Street.

15- Robert P. Harrison, UNIVERSITY OF MARYLAND.

APR 27 1923 192.....

Burial Permit Clerk. Registrar.

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Apr. 25, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
..... 192.....

20-UNDERTAKER. ADDRESS
Commissioner Health.

Per. Wm. E. WOODALL

APR 27 1923

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75261

CERTIFICATE OF DEATH.

90 D75261

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 22 WARD)

2-FULL NAME Fannie Jackson

(a) RESIDENCE NO. 111 Welcome Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Horace Jackson

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed Robert P. Harrison Registrar

APR 27 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17

I HEREBY CERTIFY, That I attended deceased from September 29, 1921 to April 24, 1923,

that I last saw her alive on April 24, 1923,

and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Heart failure from

Chronic myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McKay M. D.

4-25 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL

20 UNDERTAKER Commissioner Health

ADDRESS APR 27 1923

Per Wm. E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D75262 ✓ X 49 D75262

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Cerrus (Currier)

(a) RESIDENCE NO. Principio Furnace Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown Married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant M. G. H. Record (Address)

15 Filed ..., 19 Robert F. Harrison, Burial Permit Clerk. Registrar

APR 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to April 27, 1923, that I last saw him alive on April 27, 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of April 11-

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. H. Wilkerson, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Perryville Md. DATE OF BURIAL 4/27 1923

20 UNDERTAKER Chas. L. Evans & Son ADDRESS 1180 W. Royal Ave

B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D75263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75263

CERTIFICATE OF DEATH.

X 49

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. The Union Memorial Hospital ST., 14 WARD)

2-FULL NAME Dr. Charles Blakely.

(a) RESIDENCE NO. Cocoa Florida ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen King

6 DATE OF BIRTH (month, day, and year) Jan. 5, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	53	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Agent.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nebraska.

PARENTS

10 NAME OF FATHER Nathan Blakely.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER Margaret Tuckerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Mrs. Helen Blakely

(Address) 1322 Eutaw Place

15 APR 27 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to April 26, 1923, that I last saw h[illegible] alive on April 26, 1923, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma involving glands of neck

(duration) yrs. 6 mos. ? ds.

CONTRIBUTORY (Secondary) Pneumonia.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam + path. exam

(Signed) C. B. Price, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beatrice, Nebraska	4/28 1923
20 UNDERTAKER Henry W. Means & Son	ADDRESS 805 Calvert St

To via Penn. R. R. — Mrs. Helen Blakely Escort

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D75264

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75264

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Ruppert

(a) Residence No. 521 Cleflon Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 6 1855

7-AGE. 67 yrs. 7 mo. 21 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Cecil Co. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Alfred Wells

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Christina Berger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mercy Hospital Records

(Address)

15- Robert F. Harrison, 192

Burial Permit Clerk Registrar.

APR 27 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-26-23

17- I HEREBY CERTIFY, That I attended deceased from 4-6 19 23 to 4-26 19 23

that I last saw h[illegible] alive on 4-26 19 23

and that death occurred, on the date stated above, at 2.05 m.

The CAUSE OF DEATH* was as follows:

Myocardeles

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sign & Symp

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Cathedral Cemetery	4/28, 19 23
20-UNDERTAKER,	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Be—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec. 6-9-19—H. F. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75265

D75265

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 105 S Carey St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ann Murphy

(a) RESIDENCE. No. 105 S Carey St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Timothy J. Murphy

6 DATE OF BIRTH (month, day, and year): May 14 1855

7 AGE: Years 67 Months 11 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm Whalen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Johanna Whalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Peter Burns (Sister) 105 S. Carey St.

15 Filed Apr 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 26 — 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 25, 1923, to Apr 26, 1923, that I last saw her alive on Apr 26, 1923, and that death occurred, on the date stated above, at 11-50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) Four Years yrs. ds.

CONTRIBUTORY (Secondary): None

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Henry C Bolza M. D.

Apr 26 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: April 29 1923

20 UNDERTAKER: John J Fields — ADDRESS: 1200 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of O... TION is very important. See instructions on back of ... PA... ck of certificates.

PR 27 1923

Spec.—1-10-21—M&T—1500 Blks.

(Mamie E. Wick)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75266

D75266

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1024 W Baare ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie E. Wick

(a) RESIDENCE NO. 1024 W Baare ST., 21 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband Frank Ruth Wick

6 DATE OF BIRTH (month, day, and year) April 21 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Josephine Lauil Comb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs V. Ruth 1024 W Baare

15 Filed Apr 27 1923 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1923

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to April 20, 1923,

that I last saw h[illegible] alive on April 20, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Disseminated Carcinomatosis Coma

2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Kalteyer, M. D.

(Address) 1735 Hollen St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 4/28 1923

20 UNDERTAKER: Geo Leimbach & Son — ADDRESS: 647 W Fayette St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 27 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75267

CERTIFICATE OF DEATH.

16 D75267

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 E Pratt ST., W WARD)

2-FULL NAME August Kroupa

(a) RESIDENCE NO. 1820 E. Pratt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15, 1923

7 AGE — Years: — Months: — Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: William Kroupa

11 BIRTHPLACE OF FATHER (city or town) (State or country): Zudirkla Pa.

12 MAIDEN NAME OF MOTHER: Phylis Svasek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Czecho-slovakia

14 Informant (Address): Wm Kroupa 1820 E. Pratt St.

15 APR 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1923 to April 27, 1923

that I last saw him alive on April 27, 1923

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Vincent Zoska, M. D.

, 19 (Address) 845 Watkins Pl. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — DATE OF BURIAL: July 29 1923

20 UNDERTAKER: Frank Crockson — ADDRESS: 1906 Orleans

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Matosic)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75268

CERTIFICATE OF DEATH.

90 D75268

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Jessup ST., 25 WARD)

2-FULL NAME Michael Matosic

(a) RESIDENCE NO. 1022 Bennington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susana Matosic

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or min.
63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Mathew Matosic

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Stephen Matosic

(Address) 1022 Bennington Ave

15 Filed ....., 19 .....

Robert F. Harrison, Registrar

Burial Permit Clerk.

APR 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/25, 1923, to 4/26, 1923, that I last saw h[illegible] alive on 4/26, 1923, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Fran Freedom M.D., M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Apr 30, 1923
20 UNDERTAKER Paul Crockett	ADDRESS 1906 Eastern Ave

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75269

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 D75269

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 17 Markley ave St., 27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel A Wanner

(a) Residence No. 17 Markley ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Wanner

6-DATE OF BIRTH (month, day and year) Feb 17 1878

7-AGE. 45 yrs. 2 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Butter Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Gottlieb Wanner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Klazer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Jersey

14- (Informant) Ingrid Wanner

(Address) 17 Markley ave

15- Filed 192 Robert P. Harrison, Registrar.

APR 27 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-25-23

17- I HEREBY CERTIFY, That I attended deceased from 9-1 1922 to 4-25 1923

that I last saw him alive on 4-25 1923

and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

CHR. NEPHRITIS

(Duration) 3+ yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial insuffic

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Dorsey M. D

19 (Address) 1008 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cemetery	April 28 1923
20-UNDERTAKER	ADDRESS
Mrs C Miller	2334 Jefferson St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D75270

CERTIFICATE OF DEATH

90 ✓ D75270

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2304 Avalon Ave ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Laura May Wickes

(Residence in Baltimore: No. 2304 Avalon Ave St. 68 yrs. 1 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
F	W	Single

6 DATE OF BIRTH March 9, 1855 (Month) (Day) (Year)

7 AGE 68 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Horse-
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

PARENTS

10 NAME OF FATHER Gardner Amos Wickes

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Roberta Robinson

13 BIRTHPLACE OF MOTHER (State or country)

14 I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Lula Wickes

(Address) 2304 Avalon Ave.

15 Robert P. Harrison, 191

Burial Permit Clerk. REGISTRAR

R 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 27, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from several months 190 April 27 1923 .191 to. April 27 1923 .191

that I saw h[illegible] alive on April 27 .191 23

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Complications,

(Duration) yrs. 3 mos. ds

Contributory (SECONDARY) Ephemeritis

(Duration) yrs. mos. 14 ds.

(Signed) Burnett B Gallon M. D.

April 27, 1923 (Address) 1404 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore Cem. DATE OF BURIAL Apr. 30, 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-00 D75271

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 Union Ave ST.: 25 WARD) Married park

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Puckett

(a) RESIDENCE. NO. 1133 Union ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 9-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	no	no	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Howard F Puckett

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Weaver

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Howard Puckett
(Address) Married park

APR 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1923, to April 27, 1923, that I last saw h[illegible] alive on April 2[illegible], 1923, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Anomaly of Heart (duration) no yrs. no mos. 18 ds.

CONTRIBUTORY (Secondary) Patent foreman of Ovale (duration) no yrs. no mos. 80 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Raymond Adams, M. D.

April 27, 1923 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr. 28 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Calvert St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas W. Bromwell

(a) Residence No. 530 N. Robinson St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 12-11-1856

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Dorchester Co., Md.

PARENTS

10-NAME OF FATHER, Thomas Bromwell

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Dorchester Co., Md.

12-MAIDEN NAME OF MOTHER, Helen Sanders

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Dorchester Co., Md.

14-(Informant) Municipal Hospital Records

(Address)

15-Filed Robert P. Harrison, Registrar.

MAR 27 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 25 19 23 to April 27 19 23

that I last saw him alive on April 26 19 23

and that death occurred, on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McKay M. D

1-27- 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md — DATE OF BURIAL, April 28 1923

20-UNDERTAKER Wm Cook — ADDRESS 506 E North

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75273

CERTIFICATE OF DEATH.

6 W 001 D75273

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2614 Fairmount ave Ward) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Rachel Horner

(a) Residence No. 2614 Fairmount ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C Horner

6-DATE OF BIRTH (month, day and year) May 10

7-AGE. 65 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... House keeping
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Rodgers

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore

14- (Informant) Clara Hall

(Address) 3002 Mc Elderry

15- Filed ... Robert F. Garrison, Registrar.

APR 28 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 25 1923

17- I HEREBY CERTIFY, That I attended deceased from April 24, 1923 to April 25 1923

that I last saw h[illegible] alive on ... 24 1923

and that death occurred, on the date stated above, at ... 8 A ... m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(Duration) 2 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. E. Beaun M. D

4/27, 1923 (Address) 29 W Lafayette Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn	April 1923
20-UNDERTAKER.	ADDRESS
Wendell Dippel & Son	375 Lemmon

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. For instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Cerebral Haemorrhage

Spec.—1-10-21—M&T—1500 Blks.

D75274

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D75274

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Vincent ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Crosby

(a) RESIDENCE NO. 1422 Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Solomon Crosby

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Dent

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Annie Crosby
(Address) 1422 Vincent St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1923

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to April 26, 1923, that I last saw him alive on April 25, 1923 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchs Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

4/26, 1923 (Address) 1928 Pine Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL April 28 1923

20 UNDERTAKER R. L. Parham.

ADDRESS 220 W. Hamby St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75275

CERTIFICATE OF DEATH.

5 D75275

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545 N. Carey ST., 18 WARD)

2-FULL NAME Mary Katz

(a) RESIDENCE NO. 545 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Katz

6 DATE OF BIRTH (month, day, and year) December 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Abraham Rosenbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Simon Katz (Address) 545 N Carey St

15 Filed APR 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27- 1923

17

I HEREBY CERTIFY, That I attended deceased from May, 1922, to April 27, 1923, that I last saw her alive on April 26, 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Leonard E. Beach, M. D.

, 19 (Address) 2421 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chevra Shalom Cemetery	April 29 1923
20 UNDERTAKER J. Ahrens & Co	ADDRESS 1611 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be carefully answered. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75276

CERTIFICATE OF DEATH.

101-00 D75276

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 59 W.West ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Corsey

(a) RESIDENCE NO. 59 W. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (?)

6 DATE OF BIRTH (month, day, and year) (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) MD.
(State or country)

PARENTS

10 NAME OF FATHER (?) unknow

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Unknown

14 Informant Mary Stevens
(Address) 115 Peach alley

15 Robert P. Harrison, M. D.
Registrar

R 28 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25/23 19

17

I HEREBY CERTIFY, That I attended deceased from 4/18 , 19 23 , to 4/25/23 , 19 ,

that I last saw her alive on 4/25/23 , 19 ;

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Unresolved)

About 1 mo. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General delility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. Carroll M. D.

4/27 , 1923 (Address) 140 W. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	April 28 1923
20 UNDERTAKER	ADDRESS
J. H. Brown & Son	1811 Mtby

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75277 / 31 / D75277

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 W. 31st. St.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Herman Miller

(a) RESIDENCE. No. 303 W. 31st. St. 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Carlos Miller

6 DATE OF BIRTH (month, day, and year) March 25 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr Hamshire

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Milltown Md

PARENTS

10 NAME OF FATHER Isaac Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Redding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Mrs Robt. Miller (Address) 303 W 31st. St.

15 Filed APR 28 1923 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to Apr 26, 1923, that I last saw h— alive on Apr 26 1923, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Sputum

What test confirmed diagnosis?

(Signed) A Rehrmann, M. D.

Apr 28 1923 (Address) 865 W. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	4/28 1923
20 UNDERTAKER	ADDRESS
D. C. Marshall	3539 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of time is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75278 D75278

100-007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1630 Linden ave St., 34 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emma Whitaker Lacy

(a) Residence No. 1630 Linden ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 26 1843

7-AGE, 79 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Ill

PARENTS.

10-NAME OF FATHER Benjamin Whitaker

11-BIRTHPLACE OF FATHER (City or town) (State or Country). N.Y.

12-MAIDEN NAME OF MOTHER, Delia Hood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Benjamin Lacy

(Address) 1630 Linden ave

15- Filed ..... Robert P. Harrison, Registrar.

APR 28 1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 27-1923

17- I HEREBY CERTIFY, That I attended deceased from April 20, 1923, to April 27, 1923.

that I last saw h.. alive on April 27, 1923

and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptoms

(Signed) A. T. Robinson, M. D.

4/28 1923 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, April 30 1923

20-UNDERTAKER, John O. Mitchell ADDRESS 1201 W Fayette St

THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spmc.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75279

100-001

D75279

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1321 N. Leary ST.) 15 WARD)

2-FULL NAME Ellora Isabelle

(a) RESIDENCE. NO. 1321 N. Leary ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William McKinley Isabelle

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Corrie Selma Brown

13 BIRTHPLACE OF MOTHER (city or town) Calvert
(State or country) Dr. Md.

14 Informant Corrie Selma Isabelle
(Address) 1321 N. Leary St.

15 Filed ..... 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MAR 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to April 26, 1923, that I last saw h[e] alive on April 26, 1923, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) age -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Myerberg, M. D.

April 26, 1923 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr. 28 1923
20 UNDERTAKER	ADDRESS 443
James H. Dennis	Creighton

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

(Negro)

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75280

D75280

CERTIFICATE OF DEATH

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16[illegible] ...ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belinda Hess

(a) RESIDENCE NO. 1611 Aisquith ...ST., ...WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lustin Hess

6 DATE OF BIRTH (month, day, and year) Nov 23 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Fanny Conner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant [illegible]

(Address) [illegible]

Filed Mar 28 1923 . 19 ... Registrar

Robert F. Harrison

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 . 1923 . to April 27 . 1923 .

that I last saw her alive on April 26 . 1923 .

and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Valvular Heart (Mitral)

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine Examination

(Signed) Joseph T. Kenny, M. D.

. 19 (Address) 1500 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudenwood Mt. ... DATE OF BURIAL: Mar 29 1923

20 UNDERTAKER: Wm Cook ... ADDRESS: 832 E. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75281

CERTIFICATE OF DEATH.

90 D75281

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 N. Franklin ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miriah Ayers

(a) RESIDENCE NO. 743 N. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Ayers.

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Annapolis Md

PARENTS

10 NAME OF FATHER: Marcellus Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Cecelia Magruder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Evelyn Watts 743 N Franklin St

15 Filed 4 28 1923 Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/26/1923

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1923, to 4/26, 1923; that I last saw h[illegible] alive on 4/26, 1923; and that death occurred, on the date stated above, at 12:50 m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion (duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Cardiac Insuffi. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John A. Simmons, M. D.

19 (Address) 1019 Mt. Hope Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md DATE OF BURIAL 4/28 1923

20 UNDERTAKER: Samuel Handley ADDRESS 1918 Biddle

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75282

CERTIFICATE OF DEATH.

31

D75282

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Gilmor ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Borden

(a) RESIDENCE. No. 520 N. Gilmor ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown. Wilmington Del

9 BIRTHPLACE (city or town) (State or country) Wilmington Del

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER Martha Goulden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Mrs. Carlton (Address) 520 N. Gilmor St

15 Filed APR 28 1923 19 Robert P. Griffith Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1923, to April 25, 1923, that I last saw her alive on April 24, 1923, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis ?
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Foci of Infection Tonsils Adenoids
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

(Address) 1209 Brookman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	April 28 1923

20 UNDERTAKER R. E. Groth 1405 McElderry

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75283

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2152 Wolfe ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Taylor Seabreeze

(a) RESIDENCE NO. 2152 Wolfe ST., 6th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Ella Seabreeze

6 DATE OF BIRTH (month, day, and year) Nov 7-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Richard Seabreeze

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Ella Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Ella Seabreeze (Address) 2152 Wolfe St.

Filed APR 28 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to April 25, 1923, that I last saw him alive on April 25, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Val. Dis. Heart — Mitral insufficiency, 1 yr

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Chas. L. Rothrock, M. D.

, 19 (Address) 244 E. 39

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL 4/28 1923

20 UNDERTAKER J. A. Moran

ADDRESS 300 E Balto

PENALTY—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75284

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75284

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Bank ST., 1 WARD)

2-FULL NAME Margaret E. Litchfield

(a) RESIDENCE NO. 2224 Bank ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 11 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 28/11

7 AGE — Years: 11 — Months: 9 — Days: 27 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) City (State or country) .....

PARENTS

10 NAME OF FATHER Chas. D. Litchfield

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Margaut Schammit

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Margaret Litchfield (Address) 2224 Bank St.

15 APR 28 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8- 1919, to April 25. 1923.
that I last saw h[illegible] alive on April 25. 1923.
and that death occurred, on the date stated above, at 10 50 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 3 yrs. ..... mos " ds.

CONTRIBUTORY (Secondary) " "

(duration) " yrs. " mos. " ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. Heller M. D.

4/21/23 (Address) 1937 Jonquin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem — DATE OF BURIAL: Apr 28 1923

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Edmondson

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75285

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 / D75285

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Cottage Ave. ST., 27 WARD)

2-FULL NAME John Hack.

(a) RESIDENCE NO. 1 Cottage Ave ST., 27 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Hainmaster

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) House Building

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Geo. Hack (Address) 1 Cottage Ave.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

APR 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to April 27, 1923, that I last saw him alive on April 26, 1923 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Rh. Hemiplegia

(duration) ... yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Lues with resulting Paraplegia (duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. L. Wilkinson M. D.

4-27, 1923 (Address) Raspeburg, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Lutheran Cemetery	April 29 23
20 UNDERTAKER	ADDRESS
Fred Gaedner Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75286

D75286

CERTIFICATE OF DEATH.

99-001 Gardenville

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. E. Franklin Ave near Radecke Ave ST., 10 WARD)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Frederick Walker

(a) RESIDENCE NO. E. Franklin ave. near Radecke Ave. Gardenville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann. Walker

6 DATE OF BIRTH (month, day, and year) July 4th 1843

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Walker

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant William F. Walker (Address) Hagerstown Ind.

15 Filed APR 28 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25th 23, 19.., to April 25th 23, 19.., that I last saw him alive on April 25th, 19 23, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) 1 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL April 28 23

20 UNDERTAKER Frederick Lassahn Sons — ADDRESS Fulleton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Form—12-23-21—E.B.R.S.—400 Blks.

D75287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 D75287

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charles Mendelsohn

(a) Residence No. 822 N. Payson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mrs C Mendelsohn

6-DATE OF BIRTH (month, day and year): Feb 25 1845

7-AGE: 78 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Herman E Mendelsohn

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Betty ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant) Marguerite Mendelsohn

(Address) 822 N Payson St

15- Filed ..... 192.... Registrar.

Robert P. Harrison,

APR 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4-27-23

17- I HEREBY CERTIFY, That I attended deceased from 4-14 1923 to 4-27 1923

That I last saw him alive on 4-27 1923

And that death occurred, on the date stated above, at 6 55 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Femoral Hernia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 13 ds.

18-Where was disease contracted if not at place of death? Mercy Hospital

Did an operation precede death? Yes Date of 4-14-23

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) J J Kenney M D

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: APR 30 1923

20-UNDERTAKER: Geo W Little — ADDRESS 2700 EDMONDSON Ave.

Filled in should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Bankhead)

Spec.—6-9-19—11 P. Co.—1000 Bks.

D75288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75288

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Roland Avenue ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter H. Smith

(a) RESIDENCE NO. 819 Roland Avenue ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married -

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma Becker Smith.

6 DATE OF BIRTH (month, day, and year) April 26th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Austin Nichols Packing Co

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) Washington D.C.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna McDaniel

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country) Maryland

14 Informant Mrs Walter Smith
(Address) 819 Roland Ave

15 APR 28 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to Apr. 27, 1923, that I last saw h[illegible] alive on April 26, 1923, and that death occurred, on the date stated above, at 6½ a. m.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia - (Bronchial)

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert Leadenhall, M. D.

Apr 28 1923 (Address) 711 W Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park

DATE OF BURIAL APR 30 1923 19

20 UNDERTAKER Geo. A. Fuhr

ADDRESS 2700 Edmondson Ave

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75289

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ..... ST. 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob W. Eyster

(a) RESIDENCE NO. 345 E Philadelphia ST., WARD York Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Mrs. Jacob W Eyster

6 DATE OF BIRTH (month, day, and year) Aug 11 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Buyer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER John Eyster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Susan Eisenhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Robert B Eyster

(Address) Wyandotte N Y

15 Filed Robert P. Harrison, Registrar

R 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1923, to Apr 28, 1923, that I last saw him alive on Apr 28, 1923, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema - Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Retrospectoral Sarcoma (duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? Yes Date of Apr 25 1923

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York Pa. DATE OF BURIAL: Apr 28 1923

20 UNDERTAKER: W. W. Cook ADDRESS: 502 E Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Burial Permit Clerk

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75290 — CERTIFICATE OF DEATH. — D75290

REGISTERED NO. 1072

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) (WARD)

2-FULL NAME Chester E. Babylon

(a) RESIDENCE NO. Ellicott City, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Amanda Babylon

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	24	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber.

(b) General nature of Industry, business, or establishment in which employed (or employer) Barber Shop.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Babylon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Martha Grover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Hospital Records. (Address)

15 Robert P. Harrison, Registrar

APR 28 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27, 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923. to Apr. 27, 1923. that I last saw h[illegible] alive on Apr. 27, 1923. and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH* was as follows:

Suspected Pulmonary Tuberculosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of Apr. 13, 1923.

Was there an autopsy? No. What test confirmed diagnosis? Operation.

(Signed) B. M. Rhodes M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St. Louis Cem. Co. Howard Co. Apr. 29 1923

20 UNDERTAKER — ADDRESS

Easton Sons Ellicott City

R—THIS BLANK, WITH UNFAILING ACCURACY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Infection Unknown—
Not tuberculous.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75291

CERTIFICATE OF DEATH.

31 D75291

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 E. Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Jones

(Residence in Baltimore: No. 1832 E Madison St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE 40 appox yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Henry Jones

11-BIRTHPLACE OF FATHER (State or Country), Richmond Va

12-MAIDEN NAME OF MOTHER Cecelia Reed

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Adolphus Horsey (Cousin)

(Address)...1832 E Madison

15- APR 28 1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1923, to April 24 1923, that I saw h er alive on April 23 1923, and that death occurred, on the date stated above, at 10 10 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration).....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration).....yrs.....mos.....ds.

(Signed) R. T. Young M. D.

4/26, 1923. (Address) 1124 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, April 27, 1923

20-UNDERTAKER Mrs. R. C. Elliott — ADDRESS 172 William

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec- 12-23-21- E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75292

CERTIFICATE OF DEATH.

51

D75292

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., No. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hill

(a) Residence No. 921 S. 2nd St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1906

7-AGE. 16 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School-girl

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS

10-NAME OF FATHER. Walter Hill

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Minnie Hill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 28 1923 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 5, 1923 to April 27, 1923

that I last saw her alive on April 26, 1923

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Pericardial effusion (rheumatic)

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (rheumatic)

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. A. McKay M. D

4-27-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Arbury Cemetery

DATE OF BURIAL. April 29, 1923

20-UNDERTAKER. Mrs. R. A. Elliott

ADDRESS 172 E. Biddle St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—MAT—1500 Blks.

D75293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-501 D75293

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " " ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Parker.

(a) RESIDENCE No. 1627 St. Joseph St. City ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5, 1922.

7 AGE: Years — Months 10 — Days 22 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Paul Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Era Trogdon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 Filed Apr 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to April 27, 1923, that I last saw him alive on April 27, 1923 and that death occurred, on the date stated above, at 6.00 A.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia
(Interstitial).

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary): None.
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes. What test confirmed diagnosis? Examination of lungs, Post mortem

(Signed) William H. Wartten, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stafford Co. Va. — DATE OF BURIAL: April 29 1923

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1725 Eutaw

INFORMATION, WITH CAUSE OF DEATH, REQUIRED BY LAW. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75294

CERTIFICATE OF DEATH.

5129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2135 Chelsea Terrace ST., 15 WARD)

2-FULL NAME James H. Barrow

(a) RESIDENCE NO. 2135 Chelsea ave Terrace ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Barrow

6 DATE OF BIRTH (month, day, and year) July 17 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Advertising Salesman 066

(c) Name of employer Self Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Thomas H Barrow Md.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ma

12 MAIDEN NAME OF MOTHER Mary Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry Barrow (Address) 2135 Chelsea

15 Robert F. Harrison, .19 Registrar

Burial Permit Clerk.

R 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 .1923. to Apr 27 .1923.

that I last saw him alive on Apr 27 .1923.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Arterio Sclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis about 4 mos. ds.

(duration) yrs.

18 Where was disease contracted ——

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical + Laboratory findings

(Signed) W. S. Niblett, M. D.

Apr 27, 1923 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 4/30 1923

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins sts.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

75-295 HEALTH DEPARTMENT--CITY OF BALTIMORE

D75295

CERTIFICATE OF DEATH

129 D75295

(REGISTERED NO. C .....)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3910 Eastern Ave ST. 76 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Mounds

(Residence in Baltimore: No. 3910 Eastern Ave St.: 65 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male,

4-COLOR OR RACE White,

5-SINGLE, MARRIED, WIDOWER OR DIVORCED (Write the word) Single,

6-DATE OF BIRTH ..... (Month) Jan (Day), 1858 (Year)

7-AGE 65 yrs. 3 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Stone-mason,
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Balto. Md.

PARENTS

10-NAME OF FATHER Patrick Mounds,

11-BIRTHPLACE OF FATHER (State or country) Ireland.

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or country) Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frances Mounds

(Address) 2430 Foster Ave.

15 Filed APR 29 1923 191 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April (Month) 26 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to April 26, 1923,
that I saw h[illegible] alive on April 26, 1923,
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:

Anaemia,
Chronic Interstitial Nephritis,
(Duration) ..... yrs. 6 mos. ..... ds
Contributory (SECONDARY) Angina Pectoris,
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. E. McClanahan M. D.
April 26, 1923 (Address) 3506 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL 4/30/1923

20-UNDERTAKER J. J. Moran ADDRESS 3000 E. Baltimore St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

75296 HEALTH DEPARTMENT—CITY OF BALTIMORE

D75296 CERTIFICATE OF DEATH. D75296

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Farrell

(a) Residence No. 211 W. 10th St. Tyrone St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 11 1860

7-AGE. 62 yrs. 5 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) P.R.R.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Penna

PARENTS.

10-NAME OF FATHER, John Farrell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ann Devlin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mercy Hosp. Records

(Address)

15- FILED APR 29 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-28-23

17- I HEREBY CERTIFY, That I attended deceased from 4-17, 1923 to 4-28, 1923

that I last saw him alive on 4-28, 1923 and that death occurred, on the date stated above, at 10 20 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) 6 mos.

CONTRIBUTORY (Secondary) Hemorrhage Pers

(Gastric) (Duration) 3 mos.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. J. [illegible] M.D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Tyrone, Pa. DATE OF BURIAL, 4/28/ 1923

20-UNDERTAKER. E. J. Fanning & Son ADDRESS 1938 Lafayette Ave.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75297

CERTIFICATE OF DEATH.

31 D75297

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 Mosher ST.: 16 WARD)

2-FULL NAME. Reginia Daniels

(a) RESIDENCE. NO. 1321 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James Daniels

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Newborn N. C.

12 MAIDEN NAME OF MOTHER Ethel Roy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Blanche Roy Jones
(Address) 1934 Druid Hill Ave

15 Filed APR 29 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1923, to April 25, 1923, that I last saw her alive on April 25, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage 1/2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Phthisis Pulmonary

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? 1321 Mosher

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H Magee, M. D.

April 26, 1923 (Address) 1209 Preston and St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr. 27 1923
20 UNDERTAKER John H. Tradwin	ADDRESS 1027 Druid Hill Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75298

CERTIFICATE OF DEATH.

X 100-001

D75298

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 Myrtle ave, St.: 4 Ward) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marinda Taylor

(a) RESIDENCE. No. 213 Myrtle ave St., Ward. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launderess.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Taylor

(Address) 744 W. Fremont St

15 Filed APR 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to April 27, 1923

that I last saw her alive on April 27, 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Esclerosis

Broncho Pneumonia

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Harry Glassman, M. D.

April 28 1923 (Address) 2642 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Taylors Wolf Va	4-30 1923
20 UNDERTAKER David Easton	ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

ok. M Journal
or M. S.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002 D75299

D75299

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 W. Franklin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Fradin

(a) RESIDENCE. No. 410 N. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Henry Sonneborn & Co.

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sam. Fradin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Markowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis Fradin, 106 N. Washington St.

15 Filed APR 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to April 28, 1923, that I last saw her alive on April 28, 1923, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Novocaine Intoxication

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Private Home

Did an operation precede death? Yes Date of April 25, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles L. Tackler, M. D.

4/30 1923 (Address) 625 W. F

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Co. DATE OF BURIAL 4/29 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt

Nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic tonsillitis

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75300

D75300

CERTIFICATE OF DEATH.

46

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abner Crampton

(a) Residence No. 433 E. Fort Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas Crampton

6-DATE OF BIRTH (month, day and year) January 5 1859

7-AGE. 64 yrs. 3 mos. 23 ds. If Less than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, — Riggins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-(Informant) Thomas Crampton

(Address) 433 E Fort Ave

15-FILED APR 29 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4/27/23

17-I HEREBY CERTIFY, That I attended deceased from Apr 20 1923 to Apr 27 23 19.....

that I last saw h.. alive on Apr 27/23 19.....

and that death occurred, on the date stated above, at 11 21 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Apr 20/23

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H B Cole M. D.

(Address) 1124 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL, Apl 30 1923

20-UNDERTAKER Jos Syfer 1600

ADDRESS N North Ave

Should be carefully supplied. ALL should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21 E.B.R.S. 400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75301

CERTIFICATE OF DEATH.

90

Registered No. D75301

1-PLACE OF DEATH

City of BALTIMORE: (No. Tudor Hall Apts St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Warren Ellard

(a) Residence No. Tudor Hall Apts St., 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 55 yrs. 7 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Adeline L. Ellard

6-DATE OF BIRTH (month, day and year) Sept-6-1867

7-AGE. 55 yrs. 7 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Priest of Toronto

(b) General nature of industry, business, or establishment in which employed (or employer). Heating & Fuzing Company

(c) Name of employer.....

9-BIRTHPLACE (city or town) Boston (State or Country), Mass.

PARENTS.

10-NAME OF FATHER, John Ellard

11-BIRTHPLACE OF FATHER (city or town) Boston (State or Country). Mass

12-MAIDEN NAME OF MOTHER, June ? ? ? ?

13-BIRTHPLACE OF MOTHER (city or town) Boston (State or Country). Mass

14- (Informant) Mrs J. W. Ellard (wife)

(Address) Tudor Hall Apts.

15- Filed APR 29 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27 1923

17- I HEREBY CERTIFY, That I attended deceased from March 19 21 to April 27 19 23

that I last saw him alive on April 26 19 23

and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Cerebrosclerosis

Myocarditis 2 months

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Arteriosclerosis Thrombosis 1

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. A. H. A. Mayer M. D

11.28, 1923 (Address) 2438 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn - Mass. DATE OF BURIAL. Apr 29, 1923

20-UNDERTAKER. STUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

See ... Exact statement of OCCU... classified. ... should be stated in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D75302

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 70 WARD)

2-FULL NAME Mrs Margaret Donnelly.

(a) RESIDENCE No. 3303 Bechs Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced, (write the word)~~: Widowed

5a ~~Married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	✓			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs Matthews 2303 Bechs Lane

15 Filed APR 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to April 27, 1923.

that I last saw he alive on April 27, 1923,

and that death occurred, on the date stated above, at 3 17 A.M.

The CAUSE OF DEATH* was as follows:

Fracture - rt. femur (Barcy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) Karl Steinmueller, M. D.

4/27, 1923 (Address) 527 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: 4/30 23

20 UNDERTAKER: J J Crane & Son

ADDRESS: Gilmor St

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75303 X129 D75303

CERTIFICATE OF DEATH.

D75303

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 17 Union Ave ST.: (or WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Knight

(a) RESIDENCE. NO. 17 Union Ave ST., WARD. St Louis

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Servant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Rachel Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Bridget Keene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 INFORMANT (Address) 17 Union Ave

15 APR 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to April 27, 1923, that I last saw h[illegible] alive on April 27, 1923, and that death occurred, on the date stated above, at 5:10 m.

The CAUSE OF DEATH* was as follows:

La Grippe

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grunstein, M. D.

4/29 1923 (Address) 517 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	April 30 1923

20 UNDERTAKER M Lahey & Sons ADDRESS 1837 [illegible]

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75304

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 129 D75304

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital ST., 17 WARD)

2-FULL NAME George T Erwin

(a) RESIDENCE NO. 663 W Franklin ST., ... WARD ..... New York.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Irwin nee Eichman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	—		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brantford
(State or country) Canada.

PARENTS

10 NAME OF FATHER [illegible] Irwin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England.

12 MAIDEN NAME OF MOTHER Hannah Foden

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England.

14 Informant Isabel M Irwin
(Address) 245 W 14th St. N.Y.

15 APR 29 1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apl 28 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1923, to apl 28, 1923, that I last saw h- M- alive on apl 27th, 1923, and that death occurred, on the date stated above, at 5 20 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernst Goldman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brantford Ont.	April 29 1923
20 UNDERTAKER	ADDRESS
W. M. Routson	2238 N Charles

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75305 — 179 — D75305

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 S. Carey ST., 21 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte E Crumbine

(a) RESIDENCE NO. 1109 S. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Enoch L. Crumbine

6 DATE OF BIRTH (month, day, and year) Dec 9, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Abram Barnhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Enoch Crumbine
(Address) 1109 S Carey

15 APR 29 1923 Burial Permit Issued ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1923, to April 28, 1923, that I last saw her alive on Apr 28, 1923, and that death occurred, on the date stated above, at 8 05 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Wesley Hoag, M. D.

19 (Address) 729 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md, Frederick | DATE OF BURIAL May 1 1923

20 UNDERTAKER H M Cook | ADDRESS 502 E Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75306 D75306

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 W. Baltimore ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Brehm

(a) RESIDENCE. NO. 828 W Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Brehm

6 DATE OF BIRTH (month, day, and year) Feb. 11th 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56.	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Frederick Shaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant: Emma Mustgrove
(Address) 1655 Columbia Ave

15 Filed APR 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from October, 1920, to April 28, 1923,

that I last saw her alive on ....., 19..,

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
Sudden
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis
several
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical Diagnosis

(Signed) V. W. Keown, M. D.

4/29 1923 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemt	May 1 1923

20 UNDERTAKER ADDRESS

William Cook 5026 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75307 — 129 — D75307

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1943 Clifton Ave ST., 15 WARD)

2-FULL NAME Annie Elizabeth Zeigler

(a) RESIDENCE NO. 1943 Clifton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Ziegler

6 DATE OF BIRTH (month, day, and year): July 30-1846

7 AGE: 76 Years; 9 Months; ... Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS

10 NAME OF FATHER: Frederick Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Chester A Bull
(Address) 1943 Clifton Ave

15 Filed APR 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20- 1923, to Apr. 28- 1923.
that I last saw her alive on Apr. 28- 1923,
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

about
(duration) — yrs. 6 mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam. Urine

(Signed) Chas. L. McCardell, M. D.

19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 1 1923

20 UNDERTAKER: W. Cook — ADDRESS: 502 E. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75308

CERTIFICATE OF DEATH.

105 D75308

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 N Bentley ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G Geddes

(a) RESIDENCE NO. 907 N Bentley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Geddes

6 DATE OF BIRTH (month, day, and year): July 22 1852

7 AGE: Years 71 Months 9 Days

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laboring

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bartlett & Hayward

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Geddes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Letitia McKay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Eva Geddes

(Address) 907 N Bentley St

APR 29 1923

Filed

ROBERT R. KRAUTER, Registrar

J. Evans 833 N Fulton Ave Deputy Register Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28 1923

17

I HEREBY CERTIFY, That I attended deceased from April 23d 1923 to April 28th 1923,

that I last saw him alive on April 28th 1923

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Emphysema (Asthma)

for years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? observation for years

(Signed) Vincent T. Evans, M. D.

(Address) 833 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 1923

20 UNDERTAKER: William Cook

ADDRESS: 502 E Fulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

75-309

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D75309

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 340 N. Charles ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Kepner

(a) RESIDENCE NO. 340 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of The Late Tobias H. Kepner

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover, Pa.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Metzger

11 BIRTHPLACE OF FATHER (city or town) Hanover
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Hanover
(State or country) Pa.

14 Informant C.M. Kepner
(Address) Randallstown Md

15 APR 30 1923 ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 - , 1922, to Apr 27, 1923,
that I last saw h alive on Apr 26, 1923,
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of duodenum

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Not known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no-

What test confirmed diagnosis? none

(Signed) Chas. J Keller, M. D.

Apr 28 1923 (Address) 222 W monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hanover Pa	April 30 1923
20 UNDERTAKER Harry H Weitzel	ADDRESS 1531 W Lombard

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lbks. 75310

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75310

CERTIFICATE OF DEATH.

X 90 D75310

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Striebich

(a) RESIDENCE. No. Mt Hope Retreat ST. 28th WARD. Braddock Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. ? ds. How long in U. S., if of foreign birth? 73 yrs. C ? mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or WIFE of) Mrs Striebich

6 DATE OF BIRTH (month, day, and year) May 3 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	73	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment In which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) U. S. A. (?)

PARENTS

10 NAME OF FATHER John Loew

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Germany

12 MAIDEN NAME OF MOTHER M. Huckenstein

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Bavaria.

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md

15 APR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 19, 1923, to Apr 29, 1923, that I last saw her alive on Apr 29, 1923, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis - Post Senile Atherosis

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis.

abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Braddock Pa.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Braddock - Penna. DATE OF BURIAL Apr 29 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75311 HEALTH DEPARTMENT—CITY OF BALTIMORE D75311

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 S. Durham ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Jinkaud

(a) RESIDENCE NO. 710 S. Durham ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Jacob Jinkaud

6 DATE OF BIRTH (month, day, and year) Sept. 18th 1840

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Braunschweiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Kate Miller (Niece)

(Address) 1709 N. Montford ave.

15 Filed APR 30 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26th 1923

17

I HEREBY CERTIFY, That I attended deceased from April 2nd 1923, to April 26th 1923.

that I last saw her alive on April 25, 1923

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) ....yrs. ....mos 24 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edel A. Athey, M. D.

April 26th 1923 (Address) 108 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL April 30th 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 4018 Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75312

CERTIFICATE OF DEATH.

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N. Front ST., 5 WARD)

2. FULL NAME Dominick Vacca

(a) RESIDENCE NO. 404 N. Front ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1921

7 AGE	1 Years	4 Months	1 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Vincenzo Vacca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Domenica Monti

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincenzo Vacca
(Address) 404 N. Front St

15 Filed APR 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 23, 1923. to Apr. 28, 1923.

that I last saw h~~im~~ alive on Apr. 23, 1923.

and that death occurred, on the date stated above, at 1 00 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Microcephaly).

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 4/30 1923

20 UNDERTAKER George J Ruth — ADDRESS 1735 Hartford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary. Whooping Cough.

Spec.—1-10-21—M&T—1500 Blks.

D75313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75313

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3820 Falls Road ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Francis) Fracis. P. Tunney

(a) RESIDENCE NO. 3820 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Helen. F. Tunney

6 DATE OF BIRTH (month, day, and year) October- 4-1884

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or min.
	38	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk for B & O Railroad.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER William Tunney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Cashen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Helen. F. Tunney (Address) 3820 Falls Road

15 APR 30 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr.-28-1923

17

I HEREBY CERTIFY, That I attended deceased from April 22 . 1923 . to April 28 . 1923 .

that I last saw him alive on April 28 . 1923 .

and that death occurred, on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Breast Tumor (duration Many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ordinary clinical tests

(Signed) Jas M. Cunningham, M. D.

, 19 (Address) 1900 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery. DATE OF BURIAL: May-1-19

20 UNDERTAKER Henry Koch (Son ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75314

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D75314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3111 Fleet ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Henderson

(a) RESIDENCE NO. 3111 Fleet ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. C. Henderson

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer American Can Co.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Harry Henderson

(Address) 3111 Fleet St

15 Filed APR 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to April 28, 1923,

that I last saw h— alive on April 28, 1923,

and that death occurred, on the date stated above, at 3 50 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. L Loy, M. D.

4-30 1923 (Address) 2701 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 30 1923
20 UNDERTAKER	ADDRESS
H. Sander Sons	1701 East St

BEFORE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

75315 HEALTH DEPARTMENT—CITY OF BALTIMORE 75315

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3601 Chestnut Ave WARD 8)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Lorraine George

(a) RESIDENCE No. 3601 Chestnut Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 9 mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 28 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Morris George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Morris George (Address) 3601 Chestnut Ave

15 APR 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26, 1923, to Apr. 28, 1923, that I last saw h[illegible] alive on Apr. 28, 1923, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia following Rhinitis

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Beeten, M. D.

4.28. 1923 (Address) 747 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Apl 30, 1923
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

CAUSE OF DEATH in plain terms. so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75316

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1814 McHenry ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira Baker

(a) RESIDENCE NO. 1814 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The late Willard Baker

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry H. Busch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Conn.

12 MAIDEN NAME OF MOTHER Eliza Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Henry E. Busch
(Address) 1814 Mchenry St.

15 Filed APR 30 1923 ROBERT R. KRAUTH
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1923, to April 27, 1923, that I last saw her alive on April 27, 1923, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theo. A. Schaefer, M. D.

April 29 1923 (Address) 1102 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	April 30 1923

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75317 E. HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D75317

CERTIFICATE OF DEATH.

32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL Sta. 27 WARD)

2-FULL NAME Bernard Flemming Jovan

(a) RESIDENCE No. 418 Wilson Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1.	2,	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Gaskaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Irene Flemming

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed APR 30 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to April 28, 1923, that I last saw him alive on April 28, 1923, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Generalized miliary tuberculosis.

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Lumbar puncture

(Signed) A. A. Welch, M. D.

4-29 1923 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Apr 30, 23
20 UNDERTAKER	ADDRESS
Sam'l R. Chase Son	1400 Mosher

IMPORTANT: Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75318

CERTIFICATE OF DEATH.

179 ✓D75318

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marvine Johnson

(Residence in Baltimore: No. 1314 Argyle Ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. March 14 1906
(Month) (Day) (Year)

7-AGE. 17 yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bell girl
(b) General nature of industry, business, or establishment in which employed (or employer): at Hotel

9-BIRTHPLACE, (State or Country). Balto.

PARENTS:

10-NAME OF FATHER. Joshua Johnson

11-BIRTHPLACE OF FATHER, (State or Country). Balto.

12-MAIDEN NAME OF MOTHER. Susan Gilchrist ~~Gilchrist~~

13-BIRTHPLACE OF MOTHER, (State or Country). Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Johnson

(Address) 1314 Argyle Av

15-

Filed APR 30 1923 192 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Apr. 28 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns face & Thr all over, 2nd & 3rd degs
Lamp, go & accidentally fell on floor
until she was dead.

(Duration) 5 hrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Apr 28 192 3 (Address) 1659 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.... yrs. 4 mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn — DATE OF BURIAL. May 1st 1923

20-UNDERTAKER. Wm. H. Creel & Son — ADDRESS 1400 Mosher

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 75319

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 75319

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5621 Govane ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Wood

(a) RESIDENCE NO. 5621 Govane ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 27. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Alex W. Wood.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Amelia Gait

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Alex. W. Wood

(Address) 5621 Govane ave

15 APR 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1923, to April 27, 1923, that I last saw him alive on April 27, 1923 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (5 mo)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Roland Finley, M. D.

4/28, 1923 (Address) 3572 Greenmount ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	April 30 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75320 HEALTH DEPARTMENT—CITY OF BALTIMORE D75320

CERTIFICATE OF DEATH.

84

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 616 W 34 St ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas P. Mooney

(Residence in Baltimore: No. 616 W. 34 St

St.; yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 16 (Day), 1877 (Year)

7-AGE, 45 yrs. 11 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER. John C Mooney

11-BIRTHPLACE OF FATHER (State or Country). Balto Co.

12-MAIDEN NAME OF MOTHER. Mary J. Robinson

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Mooney

(Address) 616 W. 34 St

15- APR 30 1923

Filed....., 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tumor of Brain

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John F. Donovan M. D. (Coroner)

(Address) 632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oella Cemetery — DATE OF BURIAL, Apr 30 1923

20-UNDERTAKER A. S. Marshall — ADDRESS 3539 Fells Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75321 D75321

D75319 D75321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1704 N. Charles St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia A. Taylor

(Residence in Baltimore: No. 1704 N. Charles St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. July 25 1872
(Month) (Day) (Year)

7-AGE. 50 yrs. 9 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Designer (Underwear Industry)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Wm Taylor

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mary Felle

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Taylor

(Address) 1207 Park Ave

15-

APR 30 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 29 23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac disease.

for Contrib. Myocarditis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

Apr 30 1923 (Address) 1059 Bell

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	April 30 1923
20-UNDERTAKER.	ADDRESS
Jos Joerdens Son	2173 E. Pra

To state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75322

REGISTERED NO. 101-8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 N. Calhoun St.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justine Wolf (Mrs)

(a) RESIDENCE. No. 1938 Hollins St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 9-15-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of indastry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER J. Paul Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E. Wolf
(Address) 320 N Calhoun St

15 Filed . . 19 APR 30 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1923

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to April 24, 1923, that I last saw h[illegible] alive on April 24, 1923, and that death occurred, on the date stated above, at 12-30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) L. Heller Henning M. D.

4/24, 1923 (Address) 2000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 3, 1923
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 63-19—H. P. Co.—1000 Bks.

D75323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D75323

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Madeira ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Tyler

(a) RESIDENCE. No. 602 Madeira ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Tyler

6 DATE OF BIRTH (month, day, and year) Not Known 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hutchens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Henrietta Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lucenia Conway

(Address) 602 N. Madeira ST

15 Filed APR 30 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27 1923

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1923, to April 27, 1923, that I last saw h[illegible] alive on April 26, 1923, and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac disease

(duration) yrs. mos 005 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

4-28 1923 (Address) 820 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bur cemetery	April 30 1923
20 UNDERTAKER Edward Bryan	ADDRESS 631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—1-10-21—M&T—1500 Nbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75324 — CERTIFICATE OF DEATH. — 57 — D75324

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rose Stern

(a) RESIDENCE NO. 1203 N. Fulton St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hyman Stern

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE — Years: 51 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs. Rahmanoff

(Address): 1226 N. Carlton St

Filed 19 APR 30 1923 Registrar

Burial Permit Cle

ROBERT H. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1923

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1923, to April 29, 1923, that I last saw her alive on April 29, 1923, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

General Toxemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Diabetes

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Moses Gellman, M. D.

Apr. 29, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/30 1923

20 UNDERTAKER: Jack Levin — ADDRESS: 1439 E Balt

Spec.—1-10-21—M&T—1500 Blks.

(Maisie Batson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75325

CERTIFICATE OF DEATH.

10

D75325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. (WARD)

2-FULL NAME Maisie Batson

(a) RESIDENCE NO. 830 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 6 - 1915

7 AGE: Years 8 Months 2 Days 19 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. md

PARENTS

10 NAME OF FATHER: John Batson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Carl Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. md

14 Informant (Address): Sydenham Hospital

15 Filed APR 30 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to April 28, 1923, that I last saw h[illegible] alive on April 28, 1923, and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar + pharyngeal

(duration) — yrs. — mos. 9 or 10 da.

CONTRIBUTORY (Secondary): Myocarditis

duration — yrs. — mos. 4+ da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B Magruder M.D.

4/29/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: April 30-23

20 UNDERTAKER: Thos J. E. Locke

ADDRESS: 1302 Jefferson

Spec.—8-24-14—M. & T.—2000 Blks.

D75326 HEALTH DEPARTMENT—CITY OF BALTIMORE D75326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 David Hill ST.; 14 WARD) REGISTERED No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Jackson

(Residence in Baltimore: No. 1410 David Hill ave St.; ..... yrs. 30 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	Colored	Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day) 1892 (Year)

7-AGE.	If LESS than 1 day,
50 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, George Womley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotte Womley

(Address) 1460 David Hill ave

15- Filed APR 30 1923, 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1923, to April 27th 1923, that I saw h alive on April 25 1923, and that death occurred, on the date stated above, at 9a. m.

The CAUSE OF DEATH* was as follows:

Malignancy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Lightner M. D.

4.30, 1923 (Address) 411 N. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western St Catonsville	April 30, 1923.

20-UNDERTAKER	ADDRESS
Wm R a Elliott	1725 Eastlandave

important. See instructions on back of certificate.

Spec.—3-10-21—M&T—1500 Blks.

D75327 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75827

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2318 N. Calvert Street ST., 17 WARD)

2-FULL NAME George McCauley Reese

(a) RESIDENCE No. 2318 N. Calvert Street ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah Manly Reese

6 DATE OF BIRTH (month, day, and year) August 26th. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U.S. Customs Official

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S. Government

9 BIRTHPLACE (city or town) Elkton
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard George Reese

11 BIRTHPLACE OF FATHER (city or town) Cecil Co.,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Baker McCauley

13 BIRTHPLACE OF MOTHER (city or town) Cecil Co.
(State or country) Maryland

14 Informant Richard Reese
(Address) Wilmington Delaware

15 APR 30 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25 1923 to April 28 1923, that I last saw him alive on April 28 1923, and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia + influenza.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 hrs. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

(Address) 711 W Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkton, Md.	May. 1st 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D75328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 Indiana Ave (Westport ST., 25 WARD)

2-FULL NAME Harry F. Weller

(a) RESIDENCE NO. 636 Indiana Ave (Westport) ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie B. Weller

6 DATE OF BIRTH (month, day, and year) Mar. 3 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Gas & Electric Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John C. Weller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germeny

12 MAIDEN NAME OF MOTHER Maggie F. Decker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John W. Weller
(Address) 344 S. Fulton Ave.

15 Filed APR 30 1923 . 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 29th. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13 . 1922 . to April 29 . 1923 . that I last saw h alive on April 28 . 1923 . and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs and Throat

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Tuberculosis of Throat (duration) no yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Raymond S. Klaus, M. D.

Apl 30 . 1923 (Address) Lakeland Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 2 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N Calvert St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75329

HEALTH DEPARTMENT—CITY OF BALTIMORE D75329

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2821 Hudson St.; 1 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Miksa

(a) RESIDENCE. No. 2821 Hudson St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Miksa

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Slezak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Joseph Miksa (Address) 2821 Hudson

15 Filed APR 30 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22 to April 28. 23 that I last saw her alive on April 23. 23 and that death occurred, on the date stated above, at 1130a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4 months ago

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. L. Reichard M. D.

4-28-23 (Address) 3100 Abell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 1 1923
20 UNDERTAKER	ADDRESS
Frank Lovelace Son	1906 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75330

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D75330

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1151 N. Fulton Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Byers

(a) Residence No. 1151 N Fulton Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 2/1858

7-AGE. 64 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Saleslady

(b) General natnre of Industry, business, or establishment in which employed (or employer). Stewart & Co Dry Goods

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Shepherdstown West Virginia

PARENTS.

10-NAME OF FATHER, Joseph Byers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Shepherdstown W Va

12-MAIDEN NAME OF MOTHER. Susan M Clise

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pennsylvania

14- (Informant) Mrs Ella B Phelps

(Address) 1151 N Fulton Ave

15- APR 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 29. 1923

17- I HEREBY CERTIFY, That I attended deceased from April 12 1923 to April 28 1923

that I last saw h.. alive on April 28 1923

and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Dilatation Heart

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? In Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Flanders McClay M. D.

, 19 (Address) 1609 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Shepherdstown W Va	May 1, 1923
20-UNDERTAKER. Jos Styer	ADDRESS 1600 N North Ave

In plain terms, so that it may be properly classified.

instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75331

CERTIFICATE OF DEATH.

118-00

D75331

REGISTERED NO.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 10 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H. Ross

(a) RESIDENCE NO. 209 Hull Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada M. L. Ross

6 DATE OF BIRTH (month, day, and year) Mar 10 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
42	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Custom House

(b) General nature of industry, business, or establishment in which employed (or employer) employee 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Margie Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Ada M. L. Ross wife

(Address) 209 N. Durham st.

15 APR 30 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to April 26, 1923.

that I last saw him alive on April 26, 1923,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Inguinal Hernia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (B. Influ)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of April 23-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James Hubert Wilkerson M. D.

19 (Address) Mary Land General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 30-23
20 UNDERTAKER	ADDRESS
Mrs R.C. Elliott	1775 Ashland Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75332 HEALTH DEPARTMENT—CITY OF BALTIMORE D75332

CERTIFICATE OF DEATH. 160

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. [illegible] ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant child of Mr. & Mrs. David A. Celeste Bolton

(a) RESIDENCE NO. 342 South ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 27 1923

7 AGE: Years | Months | Days: 1 day. | If LESS than 1 day, ... hrs. or ..... min.: Infant.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER George D. Bolton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cokesford Harford Co. Md.

12 MAIDEN NAME OF MOTHER Adelaide C. McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: George D. Bolton

(Address) 342 E. 20th St

15 Filed APR 30 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1923, to April 28, 1923, that I last saw him alive on April 28, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald D. Towry, M. D.

, 19 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 4/30 1923

20 UNDERTAKER: Henry W. Means & Son

ADDRESS 805 Edmondson Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75333

CERTIFICATE OF DEATH.

101-001 D75333

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 532 S. Streeper St., 1st Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Benton

(a) Residence No. 532 S. Streeper St., 1st Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widow or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Benton

6-DATE OF BIRTH (month, day and year): June 12-1852

7-AGE: 66 yrs. 11 mos. 16 ds. If LESS than 1 day, ... hrs. or ... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: Wm. J. Benton

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Eastern Shore, Md.

12-MAIDEN NAME OF MOTHER: Charlotte Hubbard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md

14-

(Informant): Mary E. Neumann

(Address): 532 S. Streeper St.

15-

Apr 30 1923 192... ROBERT N. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 28. 1923

17- I HEREBY CERTIFY, That I attended deceased from April 24 1923 to April 28 1923

that I last saw h[illegible] alive on April 28 1923

and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 4 ... ds.

CONTRIBUTORY (Secondary): None

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. L. Lins M. D

4-30. 1923 (Address) 2901 Eastern

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL, May 2 1923

20-UNDERTAKER: Fielder & Fielder — ADDRESS 1739 Eager

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75334

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 4 WARD)

2-FULL NAME Baby Girl Thames

(a) RESIDENCE NO. University Hospital ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Thames

11 BIRTHPLACE OF FATHER (city or town) Coom
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Greenwood

13 BIRTHPLACE OF MOTHER (city or town) Leon
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Robert F. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1923

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to April 27, 1923, that I last saw h.e.r alive on April 27, 1923, and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis Toxemia of Pregnancy

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Norwood Wilson, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ..... 19 ..... ADDRESS APR 28 1923

20 UNDERTAKER [redacted]

[redacted]

D75335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75335

CERTIFICATE OF DEATH.

188-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. W M R R & Brooks Lane St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno Crist

(Residence in Baltimore) No. 4215 Evergreen Terrace St.; yrs. 25 mos. ds.)

10 20 mal

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. April 28 1840
(Month) (Day) (Year)

7-AGE. 83 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Frederick Md.

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). Frederick Md

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country). Frederick

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Morgan

(Address) 4215 Evergreen Ave

15- Robert F. Harrison,

16- Burial Permit Clerk. Registrar.

3 01923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 28 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.), thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

R. R. Accident
Multiple Fractures.
(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. ds.

(Signed) Geo Claudius Blades M. D.
(Coroner.)

1923, (Address) 1436 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	May 1, 1923

20-UNDERTAKER. Robt F Turner Son ADDRESS 1142 N. Broadway

Date CAUSE OF DEATH may be properly classified. Each statement is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75336 D75336

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bethlehem Ave. ST., Graceland Pk. WARD 76)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Rebetsky

(a) RESIDENCE NO. Bethlehem Ave ST., Graceland Pk. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Rebetsky.

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Steven Slezac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Steven Rebetsky (Address) Bethlehem Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

301923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1923.

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to April 29th, 1923, that I last saw her alive on April 28th, 1923, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? yes Date of May 1922

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) Frank Friedrich, M. D.

April 30 19 23 (Address) Bruns Bldg Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	May 1 1923
20 UNDERTAKER Lilly & Ziska	ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

D75337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75337

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE, No. ..... ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Castin

(a) RESIDENCE NO. Woaford, Md., ST., ... WARD Wwlford Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Susie E. Castin

6 DATE OF BIRTH (month, day, and year) Aug. 12-1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
62	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

1030

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER John Henry Castin

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Miss. Frutze

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

14 Informant ..... (Address) University Hospital Records

15 Filed 30 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/29 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/28, 1923, to 4/29, 1923, that I last saw him alive on 4/29, 1923, and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Hemiplegia

(duration) yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical signs.

(Signed) W. B. Jones, M. D.

4/30 1923 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Church Creek Md

DATE OF BURIAL: May 1923

20 UNDERTAKER: William W. Shriver

ADDRESS: 1018 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75338

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Rosalyn Ave ST., 45 WARD)

2-FULL NAME Charles A. Pole Jr

(a) RESIDENCE NO. 2309 Rosalyn Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 1918

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
5	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles A Pole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co.

12 MAIDEN NAME OF MOTHER Beulah Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles A Pole

(Address) 2309 Rosalyn Ave

15 ROBERT E. HARTLEY

APR 30 1923 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and ...) Apr. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 18 1923 to Apr 29 1923, that I last saw h[illegible] alive on Apr 29 1923, and that death occurred, on the date stated above, at 745 P m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no .....

What test confirmed diagnosis? Physical .....

(Signed) Walter S. Tibbitt M. D.

May 1 1923 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 1 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75339

CERTIFICATE OF DEATH.

45

D75339

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospt. ST., 20 WARD)

2-FULL NAME Mrs Virginia A. Thomas

(a) RESIDENCE No. 3406 Edmondson Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Samuel D. Thomas

6 DATE OF BIRTH (month, day, and year) Dec 29 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edwin S Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Sarah Dickson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Daughter

(Address) 3406 Edmondson Ave -

15 Filed , 19 Registrar

R 30 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-1923

17 I HEREBY CERTIFY, That I attended deceased from 4-25-1923, to 4-28-1923,

that I last saw h alive on 4-28-1923,

and that death occurred, on the date stated above, at 10:45 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Intestinal obstruction

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Malignant Growth of Uterus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? Yes Date of 4-25-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo A Tompkins, M. D.

, 19 (Address) 20 E Gaithers

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL London Park

DATE OF BURIAL MAY 1 1923

20 UNDERTAKER Geo W Little

ADDRESS 2709 EDMONDSON AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75340

CERTIFICATE OF DEATH.

100-001

D75340

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 N. Fulton St. 16 WARD)

2-FULL NAME Mt. Cassandra Musselman

(a) RESIDENCE NO. 1132 N Fulton ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widow

3a If ~~married~~, widowed, ~~or divorced~~
~~HUSBAND~~ of (or) WIFE of John H. Musselman

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1849

7 AGE — Years: 83 — Months: 4 — Days: 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Louisville Kentucky

PARENTS

10 NAME OF FATHER James T. Boland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Margaret Mennillo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co Md

14 Informant: Geo W Little
(Address) 2700 Edmondson Av

15 Robert P. Harrison, M. D.
Registrar

30 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 29 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to Apr 30, 1923, that I last saw h[illegible] alive on Apr. 29, 1923, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) ~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Irvin Ebaugh, M. D.

APR 29 1923 19 (Address) 700 N W Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Mt Olivet — DATE OF BURIAL: MAY 1 1923, 19

20 UNDERTAKER: Geo W Little — ADDRESS: 2700 EDMONDSON AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75341

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3654 Railroad St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecil G. Souder

(Residence in Baltimore: No. 3654 Railroad ave 8th Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. April 20 1897
(Month) (Day) (Year)

7-AGE. 26 yrs. mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Millworker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. F. W. Souder

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Susanna A. Giddings

13-BIRTHPLACE OF MOTHER. (State or Country) Howard Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace F. Souder

(Address) 3654 Railroad Ave

15-

APR 30 1923 Robert P. Harrison, M.D. Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 28 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

April 30 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Manuel M.E. Chem Howard Co. Md

DATE OF BURIAL. May 1 1923

UNDERTAKER. Horace H. Burgee

ADDRESS 363 Hall's Road

is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D75342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7/4-001

D75342

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 41 S Sticker ST., 19 WARD)

2-FULL NAME Grier M Tounsley

(a) RESIDENCE No. 41 S Sticker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Imogene V Tounsley

6 DATE OF BIRTH (month, day, and year): Dec 31 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Balto Tube Works

9 BIRTHPLACE (city or town) (State or country): Parkesburg Pa

PARENTS

10 NAME OF FATHER: Robt Tounsley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Parkesburg Pa

12 MAIDEN NAME OF MOTHER: Mary Whiteman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Parkesburg Pa

14 Informant (Address): Imogene V Tounsley 41 S. Sticker St.

Filed ... 19... Registrar

APR 30 1923

ROBERT F. HARRISON, Acting Health Commissioner.

Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1923

I HEREBY CERTIFY, That I attended deceased from April 27. 1923. to April 29. 1923.

that I last saw him alive on April 29. 1923.

and that death occurred, on the date stated above, at 12 8. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Attending Physician

(Signed) Edgar E. Travers, M. D.

, 19 (Address) 1520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkesburg Pa.

DATE OF BURIAL: May 1923

UNDERTAKER: William Cahoon

ADDRESS: 502 E Natha

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75343

CERTIFICATE OF DEATH.

71-00 ✓ D75343

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 N Amity ST., 18 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Marie Butler

(a) RESIDENCE NO. 207 N Amity ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ella Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ella Butler

(Address) 207 N Amity

15 Filed 4/30 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) April 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to April 30, 1923, that I last saw her alive on April 30, 1923, and that death occurred, on the date stated above, at 10.35A m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Revill M. D.

4/30 1923 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL 5/1 1923

20 UNDERTAKER Samuel I Hemsley

ADDRESS W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75344

CERTIFICATE OF DEATH.

4 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7324 Fayette ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia C Massey

(a) RESIDENCE No. 7682 Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Massey

6 DATE OF BIRTH (month, day, and year): Oct 21 1848

7 AGE — Years: 75 — Months: 6 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Crisfield Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: M. H. M. Walls

(Address): 728 E. Fayette St

Filed 19 Registrar

Robert P. Harrison,

Norman 2422 Fayette St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1923, to April 29, 1923, that I last saw her alive on April 28, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Interstitial Nephritis

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

April 30 1923 (Address) 2687 Mosher Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

UNDERTAKER: William Baker

DATE OF BURIAL: May 1 1923

ADDRESS: E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

01923

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75345

CERTIFICATE OF DEATH.

X 101-001 D75345

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 Fourtalawn Ave 15 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos E. Bathgate

(a) RESIDENCE NO. Delchester Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred: yrs. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	60	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer ofb

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Delchester Md.

PARENTS

10 NAME OF FATHER Charles Bathgate

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER Jane Bowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Margaret L. Bathgate (Address) Delchester Md

15 Filed MAY - 1 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 26 1923 to Apr 28 1923.

that I last saw him alive on Apr 28 1923,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia (Lobar)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Myocarditis-

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Elkton City

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole M. D.

4/30 1923 (Address) 2707 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Melville Chapel. DATE OF BURIAL: Apr 28 23

20 UNDERTAKER: W. E. Wickersham Sons ADDRESS: North Ave

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75346

CERTIFICATE OF DEATH.

155

D75346

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos Hanson

(a) RESIDENCE NO. 629 Portland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov 20-1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Amer Street Lighting Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country) ..... Md

PARENTS.

10 NAME OF FATHER James D. Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ..... Md

12 MAIDEN NAME OF MOTHER Mary Gruber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ..... Md

14 Informant Mr. John Hanson

(Address) 320 Clifton Ave

15 Filed MAY 1 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1923, to April 30, 1923,

that I last saw h[illegible] alive on April 30, 1923,

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

1 Astrocytoma of Rt Temporal

(duration) ..... yrs. ..... mos 83 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of March 8-1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

(Address) 1 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 2 1923
20 UNDERTAKER Wm Fluchner & Son	ADDRESS Nork St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid [redacted] of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Tubercular

Spec.—1-10-21—M&T—1500 Blks.

D75347 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D75347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Cider alley, 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Crawford

(a) RESIDENCE NO. 622 Cider alley WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-17-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER David Scribner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary Alton
(Address) 622 Cary St

15 Filed MAY 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-1923

17 I HEREBY CERTIFY, That I attended deceased from 4-23-1923, to 4-28-1923, that I last saw her alive on 4-28-1923, and that death occurred, on the date stated above, at 11,15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W H Campbell M. D.

4-30 1923 (Address) 611 N Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 19
20 UNDERTAKER John H. Foadem	ADDRESS 1027 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75348

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 Edlings ct ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Smothers

(a) RESIDENCE NO. 1214 Edlings ct ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 700

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs [illegible]
(Address) 1214 Edlings St

15 Filed MAY 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1923, to April 28, 1923, that I last saw h. alive on April 28, 1923, and that death occurred, on the date stated above, at 12:10 p. m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(duration) yrs. 2 mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheeler, M. D.

4/25, 1923 (Address) 2305 E. Oliver St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Mt. Auburn.	May 1st 1923
20 UNDERTAKER John H. Jordan	ADDRESS Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAY—1500 lbs.

Jaffe

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75349 44 D75349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Orph Monument St. REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Jaffe

(a) RESIDENCE NO. 1010 N Eutaw ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? 10 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Jaffe

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Joseph Joffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dunkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ben Jaffe

(Address) 1010 E Eutaw St

15 MAY 1-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/27, 1923, to 4/30, 1923.

that I last saw h alive on 4/30, 1923

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Ermin Bronchopneumonia

(duration) ..... yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary) Pneumonia of Stomach

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4/27/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert Krauter, M. D.

4/30 1923 (Address) Hebrew Orph

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	5/1 1923
20 UNDERTAKER	ADDRESS
Jack Levinson	1220 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75350

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 N Pine ST., 4 WARD)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allie Dunger

(a) RESIDENCE No. 246 N Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Allie Dunger

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Jesse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lizzie Dunger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Frank Jesse (father)

(Address) 511 N Pine

Filed MAY 1 - 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 27 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Ap 18 1923 to Ap 27 1923.

that I last saw her alive on Ap 27 1923

and that death occurred, on the date stated above, at 11:25 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) 0 yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 246 N Pine

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mic. Ex. of Sputum

(Signed) H H Bishop M. D.

(Address) 601 W Franklin

Apr 28 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5-1- 1923

20 UNDERTAKER David Easton

ADDRESS 916 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75351

CERTIFICATE OF DEATH.

90 D75351

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 E. West St.; 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sarah O'Hara

(Residence in Baltimore: No. 12 E West St.; 66 yrs., ... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dont Know (Month), 1 (Day) (Year)

7-AGE, 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Michael Corcoran

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Bray

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis O'Hara

(Address) 12 E. West St

15-

Filed MAY 1 - 1923 191..... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1st 1923, to April 27 1923, that I saw h[illegible] alive on April 27 1923, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

Chronic Nephritis (Duration) yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry D. Holt M. D.

April 30 1923 (Address) 10 S. High St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, May 1, 1923

20-UNDERTAKER M. J. Flynn

ADDRESS 1422 Light St.

Important. See instructions on back of certificate.

Spec.—1-10-23—M&T—1500 Blks.

D75352

HEALTH DEPARTMENT—CITY OF BALTIMORE D75352

CERTIFICATE OF DEATH.

100 001

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. 24 ST., WARD (Davis)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph N. Davis

(a) RESIDENCE NO. 1710 Byrd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Bay View Hospital (Address) Baltimore, Md.

15 Filed MAY 1 - 1923 ROBERT R. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to April 30, 1923.

that I last saw h alive on April 29, 1923

and that death occurred, on the date stated above, at 1.55 p. m.

The CAUSE OF DEATH* was as follows:

Bronchо-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hyderborn's Chorea

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Work.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Hedgsmith, M. D.

4/30/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL May 1 1923

20 UNDERTAKER M. D. Flynn — ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Tasker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75353

CERTIFICATE OF DEATH.

74-001 D75353

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Baker ST., 14 WARD)

2-FULL NAME Johanna Tasker

(a) RESIDENCE NO. 518 Baker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1860

7 AGE 62 Years 9 Months 26 Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Robert Douglas

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Maguder

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Estella Jay
(Address) 518 Baker St

15 Filed MAY 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from 2 P.M. May 1st 1923, to 4.30 A.M. May 1st 1923.

that I last saw h[illegible] alive on May 1st 2.30 P.M. 1923.

and that death occurred, on the date stated above, at 4.30 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

(duration) yrs. ..... mos. 4 hours ds.

CONTRIBUTORY (Secondary) Heart Disease

(duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Corbett, M. D.

, 19 (Address) 607 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL May 4 1923

20 UNDERTAKER George W. Holland ADDRESS 1634 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D75354

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75354

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2935 Belmont Ave ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma S Hessler

(a) RESIDENCE NO. 2935 Belmont ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	76	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER George Mossman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs John Stock
(Address) 2935 Belmont Ave

15 Filed MAY 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1923

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1923, to April 29, 1923.
that I last saw her alive on April 29, 1923.
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:

Senility - Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Mitchell M. D.

4/30/ 23 (Address) 2057 Hilton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 2 1923
20 UNDERTAKER	ADDRESS
Snell & Son	[illegible]

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75355

CERTIFICATE OF DEATH.

90 D75355

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7 S. Castle ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgi Daemling

(a) RESIDENCE NO. 7 S. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Doemling

6 DATE OF BIRTH (month, day, and year) March 6 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	58	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buckster 025

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Doemling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Doemling (Address) 7 S. Castle

15 Filed MAY 1 - 1923, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1922, to April 29, 1923, that I last saw h[illegible] alive on 11 a, 19 [illegible], and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Trouble

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Collenberg M. D.

, 19 (Address) 1810, E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 2 1923

20 UNDERTAKER Jos. L. Berr — ADDRESS 156 N. Luzerne

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75356

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D75356

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1010 S. East ave ST., WARD)

2-FULL NAME Mrs Mary J Haupt

(a) RESIDENCE NO. 1010 S. East ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Haupt

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John E. Mulholland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ella Mackie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James E. Haupt
(Address) 1010 S. East ave

15 MAY 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1923, to April 28, 1923, that I last saw her alive on April 28, 1923 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs 2 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Sutton, M. D.

4/30, 1923 Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL May 2 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 4038 Main

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D75357

D75357

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 509 So. Milton Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wicenty Stelmaszak,

(a) RESIDENCE No. 509 So. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 35 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Stelmaszak,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer, 040

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER John Stelmaszak,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Karczamorik,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant M. F. Sadowski. For Katharine Stelmaszak.

(Address) 509 So. Milton Ave

15 MAY 1-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1923

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1923, to April 28, 1923, that I last saw him alive on April 29, 1923, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

April 30, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	5/1 - 1923
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St.

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D75358

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1rr West 23rd ST., 12 WARD)

2-FULL NAME Lilly Shannonhouse

(a) RESIDENCE NO. 12 West 23rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Shannonhouse

6 DATE OF BIRTH (month, day, and year) May 1 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Culpepper (State or country) Va.

PARENTS

10 NAME OF FATHER John Carter.

11 BIRTHPLACE OF FATHER (city or town) Culpepper (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Culpepper (State or country) Va.

14 Informant Rose Shannonhouse (Address) 12rr W 23 St.

15 Filed MAY 1 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 19 23

17 I HEREBY CERTIFY, That I attended deceased from April 1923, to April 28 1923.

that I last saw her alive on Apr 27 1923, and that death occurred, on the date stated above, at Apr 29 1923 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bowers L. Lamb, M. D.

4/30, 1923 (Address) 1707 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	May 1 1923
20 UNDERTAKER	ADDRESS
Jno. G. H. Hofer	426 W. Lanvale

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75359

CERTIFICATE OF DEATH.

74-001 D75359

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1239 N. Broadway St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Horstman

(Residence in Baltimore: No. 1239 N. Broadway St.; ....yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1879
(Month) (Day) (Year)

7-AGE, 44 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundry 045
(b) General nature of industry, business, or establishment in which employed (or employer): Manufacturer

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER John Horstman

11-BIRTHPLACE OF FATHER (State or Country) Baltimore City

12-MAIDEN NAME OF MOTHER Alice Lynch

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pauline Horstman

(Address) 1239 N. Broadway

15- MAY 1 - 1923 191.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 27, 9:30 p.m. 1923, to Ap. 29, 9 A.M. 1923, that I saw him alive on April 29. 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. 32 Years ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. ... mos. ... ds.

(Signed) W. C. Sandrock M. D.

May 1, 1923 (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL, 5/2, 1923

20-UNDERTAKER: M Fahey & Sons

ADDRESS 1816 South

Important. See instructions on back of certificate.

Spec.—1-10 21—M&T—1500 Bks.

D75360

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D75360

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Veterans' Hospital #56, Fort McHenry, Baltimore, Md.

CITY OF BALTIMORE: (NO. ..... ST., 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Godfrey

(a) RESIDENCE NO. 2206 Thirteenth St., N.W., Washington, D.C. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, [illegible] (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: --

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 33 — Months: - — Days: -- — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Georgia --

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown "

14 Informant: Hospital Records

(Address): Fort McHenry, Baltimore, Md.

15 Filed 4/26, 1923 ROBERT B. KRAUTER, H. W. Riess, Burial Permit Clerk. Registrar

1-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1921, to April 26, 1923, that I last saw h[illegible] im alive on April 26, 1923, and that death occurred, on the date stated above, at 11:25 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary.

(duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test.

(Signed) [signature] Surgeon (R), M. D.

4/26, 1923 (Address) Fort McHenry, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: 4/1 1923

20 UNDERTAKER: [illegible] Bro — ADDRESS: 1127 E Baltimore St

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75361 HEALTH DEPARTMENT—CITY OF BALTIMORE D75361

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Boyview Hospital Registered No.....

City of BALTIMORE: (No.....St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Fisher

(a) Residence No. 1207 N. Wolfe St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	Colored	Widower

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1879

7-AGE.	If LESS than 1 day.
43 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). ?

12-MAIDEN NAME OF MOTHER. Eliza Fisher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland.

14- (Informant) Municipal Hospitals

(Address) Records

Filed MAY 1 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/26/23

17- I HEREBY CERTIFY, That I attended deceased from 4/17/23, 19..., to 4/26/23, 19..., that I last saw him alive on 4/25/23, 19..., and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 14 yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McKay M. D.

, 19 (Address) Boyview Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cloverdale Cemetery	May 1, 1923
20-UNDERTAKER	ADDRESS
Wm. R. Ac Elroy	1212 Eutaw

Instructions on back of certificates.

Form—12-23-21—E.H.F.S.—400 Blks.

D75362 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D75362

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jennie Washington

(a) Residence No. 1232 W. 20th St. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) July 16 1868

7-AGE, 54 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cook. Ord

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Edward Washington

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Agnes Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Mercy Hospital

(Address) Baltimore

15- Filed MAY 1 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 28 '23

17- I HEREBY CERTIFY, That I attended deceased from April 7. 19 23 to April 28 19 23

that I last saw h.. alive on April 28 19 23

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma

Rectum.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? Colostomy

Did an operation precede death? Yes Date of 4-24-23

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) J. J. Swaney M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 1 19 23
20-UNDERTAKER	ADDRESS
Mrs. K. A. Ellis	1125 Eastlandia

instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75363 — CERTIFICATE OF DEATH. — D75363

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 74 Columbia Ave St.) Raspeburg Md WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Daffin

(Residence in Baltimore: No. 74 Columbia Ave. Raspeburg Md St.: 72 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, October (Month) 1 (Day), 1850 (Year)

7-AGE, 72 yrs. 6 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cooper helper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph H Daffin

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma Hettel

13-BIRTHPLACE OF MOTHER (State or Country), Bath

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Sadie Daffin .....

(Address)..... 47 Columbia .....

15- Filed MAY 1 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 29 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 1922, to April 29 1923, that I saw him alive on April 29 1923, and that death occurred, on the date stated above, at 9.55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver (secondary)

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Adeno Carcinoma Stomach

(Duration) 1 yrs. 6 mos. ..... ds.

(Signed) William A. Frank M. D.

Apr 30, 1923 (Address) 2036 Druid Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Wendell Oppel	May 2 1923
20-UNDERTAKER	ADDRESS
D Oland	3781

Important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75364

CERTIFICATE OF DEATH.

129 D75364

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 E 30 — 82 ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Ann Sears

(a) RESIDENCE. No. Ambrw apts ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word)
F	W.	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of James Sears

6 DATE OF BIRTH (month, day, and year) January 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chester Pa.

PARENTS

10 NAME OF FATHER Thos. Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chester, Pa.

12 MAIDEN NAME OF MOTHER Catherine Harrigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chester Pa

14 Informant Mrs Pearl Bausch
(Address) 20 Ordnon Apts

15 Robert [illegible], 19

Registrar

-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to May 1, 1923, that I last saw h[illegible] alive on April 30, 1923, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jefferies Buell M. D.

5/1, 1923 (Address) 2844 82 Pans 82

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Upper Marlboro Prince Georges	May 3 1923

20 UNDERTAKER ADDRESS

Wm Cook 501 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75365

161-001 D75365

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 419 E. 25th St. 12 WARD)

2-FULL NAME Grace Marquette McCallister

(a) RESIDENCE NO. 419 E. 25th ST., 12 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21 - 1923

7 AGE — Years: | Months: | Days: 11 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel L McCallister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marguerite Goldrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Samuel L McCallister
(Address) 419 - E - 25th

15 Filed May 1 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1923

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1923, to May 1, 1923, that I last saw h[illegible] alive on April 30, 1923 and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Inanition Caused by prematur birth, Marasmus

..... (duration) ..... yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Thos J Pillsbury Jr M. D.

, 19 (Address) 419 Cedarcroft Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery | DATE OF BURIAL May 1 1923

20 UNDERTAKER Wm Cook | ADDRESS So 2 E York St

CAUSE OF DEATH is very important See instructions on back of certificates. Every statement that it may be properly classified. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75366

CERTIFICATE OF DEATH.

117 D75366

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp. ST., 13 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Seward.

(a) RESIDENCE NO. 714 Newington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) April 8, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	5 yrs	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Weston Seward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Edith Thomlenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Weston W. Seward
(Address) 714 Newington Ave

15 Filed ..... 19 ..... Registrar Robert P. Harrison,

Burial Permit Clerk

-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1923 to April 30, 1923.

that I last saw her alive on April 30, 1923,

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis. (Acute)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 5

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Andrew Kyselowski, M. D.

19 (Address) St. Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL May 2 1923

20 UNDERTAKER Wm Cook 802 E

ADDRESS Northad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of certification is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D75367 34

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75367

CERTIFICATE OF DEATH.

X 49

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emmett Martin

(a) RESIDENCE NO. Smoot, W. Va. ST., WARD (Smoot W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER W. F.

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mary Nicheser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 Filed Robert P. Garrison, Registrar

-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1923

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1923, to April 30, 1923, that I last saw him alive on April 30, 1923, and that death occurred, on the date stated above, at 9.00 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-epithelioma of testicle

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Multiple metastases from tumor (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb-1921

Was there an autopsy? No

What test confirmed diagnosis? Sections of tumor-

(Signed) V Betterman, M. D.

5-1, 1923 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Romservert W Va	May 1 1923
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75368

D75368

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2817 Erdman Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Fanning

(a) RESIDENCE. No. 2817 Erdman Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Florence Fanning

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Controller

(b) General nature of industry, business, or establishment in which employed (or employer) Financial

(c) Name of employer Baltimore Acceptance Corp New York Corp

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Edward

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Nora Kane

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Brother John Fanning
(Address) 1843 Vernon St. Washington D C

15 Filed 1-1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 23, 1923, to Apr 30, 1923, that I last saw h[illegible] alive on Apr 30, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (bilateral)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical, blood, sputum

(Signed) Franklin Ebaugh, M. D.

, 19 (Address) 807 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bronx New York — DATE OF BURIAL: May 1st 1923

20 UNDERTAKER: Leo G. Cook — ADDRESS: North & Harford

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

Y

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75369

CERTIFICATE OF DEATH.

49

D75369

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2024 E. 31st ST., 9 WARD)

2-FULL NAME Mary E. Reisenweber

(a) RESIDENCE NO. 2024 E. 31st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Henry Reisenweber

6 DATE OF BIRTH (month, day, and year) Sept. 23/72

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Capt Geo. League

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah E. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry Reisenweber

(Address) 2024 E. 31st St

15 1-1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5th, 1922, to Apr. 28, 1923, that I last saw h[illegible] alive on Apr. 28, 1923 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Pelvis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) A. Leitheiser, M. D.

, 19 (Address) 1340 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL May 2 1923

20 UNDERTAKER Philip Henrig

ADDRESS 2016 Orleans

CAUSE OF DEATH must be properly classified. Exact statement may be required. See CPA-TION on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75370

CERTIFICATE OF DEATH.

74-001 D75370

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Bolton ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME H. Monroe Stubbins

(a) RESIDENCE NO. 1213 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger

(b) General nature of industry, business, or establishment in which employed (or employer) for

(c) Name of employer Merrikin & Merrikin

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Chas. Stubbins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Andrewzilla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Yingling

(Address) 1715 Bentalou St

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 30 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923 to April 30 1923

that I last saw h/m alive on April 29 1923

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

from both (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H H Crosbans M. D.

430 1923 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 2 1923
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Aliceanna

CAUSE OF DEATH is very important. See instructions on back of certificates. Exact statement of OCCUPA-tion that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75371

D75371

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 S. First St. St.: 27 WARD)

2-FULL NAME Catherine Ratkowski.

(a) RESIDENCE. NO. 917 S. First St ST., 27 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ratkowski.

6 DATE OF BIRTH (month, day, and year) Jan. 11 — 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Kinnaith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) John Ratkowski. 917 S. First St.

15 Filed 5-3-1923 Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/27/23, 19..., to 4/29, 19 23, that I last saw her alive on 4/28/23, 19..., and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis endocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. McGarrell, M. D.

5/1, 1923 (Address) 633-5-3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL May 3 1923.

20 UNDERTAKER Lilly & Ziehr

ADDRESS 403 S. Wolfe St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75372

CERTIFICATE OF DEATH.

74-001 D75372

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 177 Montebello Terrace ST.. 27 WARD)

2-FULL NAME Johanna Dittmar-Hafer.

(a) RESIDENCE. No. 177 Montebello Terrace ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hafer.

6 DATE OF BIRTH (month, day, and year) Jan. 26-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Eppert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Fred. H. Gunther (Daughter)
(Address) 177 Montebello Terrace

15 1-1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1923, to April 29, 1923, that I last saw her alive on April 29—, 1923, and that death occurred, on the date stated above, at 9.48 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Coma —

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Max Mueller, M. D.

4/25 19 (Address) 185 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz. Cem	May 7 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4038 Wolfe St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Burial Permit Clerk

D75373

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D75373

129

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 424 S. Highland Ave ST. 7th WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Michael Hoehn

(Residence in Baltimore: No. 424 S. Highland Ave Sn. 38 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Nov. 1st (Month) (Day), 1884 (Year)

7 AGE: 38 yrs. 5 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Riveter
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Hoehn

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kunigunda Kotschenreuter

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Hoehn

(Address) 424 S. Highland Ave

15 Robert P. Harrison,

Burial Permit Clerk 191 REGISTRAR

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 28 (Month) (Day), 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1913, to, Apr. 28 1913, that I saw him alive on Apr. 28, 1913, and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY): Acute Alcoholism

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Frank A. Glantz M. D.

Apr. 30, 1913 (Address) 3244 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: April 2, 1913

20 UNDERTAKER: Lilly & Zeile ADDRESS: 403 S. Wolfe St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75374

CERTIFICATE OF DEATH.

100-001

D75374

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3406 Myrtle Place ST., 26 WARD)

2-FULL NAME Martha E. Reilly

(a) RESIDENCE NO. 3406 Myrtle Place ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER James J. Reilly

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Albert

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant James J. Reilly
(Address) 3406 Myrtle Place

15 Filed ....., 19..... Registrar
1923 Robert D. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to April 30, 1923, that I last saw her alive on April 30, 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) acute Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Schleeder, M. D.

May 1, 1923 (Address) 3307 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL May 4 1923.

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Broadway

IMPORTANT—Certificate may be properly classified. Exact statement of OCCUPATION on back of certificates.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D75375

1 PLACE OF DEATH

CERTIFICATE OF DEATH

101-004

D75375

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 3320 Foster Ave ST. ..... WARD) 76

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Catherine Marie Stahl

(Residence in Baltimore: No. 3320 Foster Ave St.; 10 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): M[illegible]

6 DATE OF BIRTH: March (Month) 30 (Day), 1879 (Year)

7 AGE: 43 yrs. 1 mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9 BIRTHPLACE (State or country): Utica, New York.

PARENTS

10 NAME OF FATHER: John Welch

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Donovan

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Henry Stahl

(Address) 3320 Foster Ave

15 Robert P. Harrison, ..., 191.....
Burial Permit Clerk REGISTRAR

1-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 30 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to April 30 1923, that I saw h[illegible] alive on Apr. 30, 1923, and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

(a) Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 8 ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank A. Glantz M. D.

May 1st, 1923 (Address) 3244 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Schwartz Cem. DATE OF BURIAL: May 3, 1923

20 UNDERTAKER: Lilly & Zeile ADDRESS: 403 S. Wolfe St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75376 D75376

CERTIFICATE OF DEATH.

REGISTERED No. C 5113

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1857 Kavanaugh ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Cuff

(Residence in Baltimore: No. 1857 Kavanaugh St. St.: 1 yrs., mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	colored	single

6-DATE OF BIRTH, April 17, 1922
(Month) (Day) (Year)

7-AGE, 1 yrs. mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Infant.....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Geo. Cuff

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Hattie Lisle

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geo. Cuff

(Address) 1857 Kavanaugh

15- Filed 1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an....inquest.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said....inquest.... (Inquest, autopsy or inquiry.) ....find that said deceased came to....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) ....yrs. ....mos. 3 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)
April 29, 1923. (Address) 2802 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 1923

20-UNDERTAKER Commissioner Health.

ADDRESS MAY 1 - 1923

Par. Wm. E. WOODALL

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75377

CERTIFICATE OF DEATH.

31 V

D75377

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1900 W Baltimore ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Lippitt

(Residence in Baltimore: No. 1052 Raborg St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... September 1 .....
(Month) (Day) (Year)

7-AGE, ...65.... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... NH .....

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- 1923 Robert L. Harrison, Registrar.

Burial Permit Clerk

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... April 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) 1 yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Dilatation Heart Sudden

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W. Bond M. D.
(Coroner.)

April 30, 1923 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER Commissioner Health,	ADDRESS

UNIVERSITY OF MARYLAND.

Per. Wm. T. Wilson

MAY 1-1923

important. See instructions on back of certificate.

(See Affadavit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75378

D75378

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 18 Ward) 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Schunk (Schunt) ~~John Shanks~~

(a) Residence No. 808 Pratt St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1860

7-AGE. 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Trunk Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Shanks

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Caroline Winzel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Municipal Hospital Record

(Address)

15- Filed 1-1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 1 19 23 to April 28 19 23 that I last saw h... im... alive on April 27 19 23 and that death occurred, on the date stated above, at 4:15 A. M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Syphilis of aorta

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Hickey M. D.

4-28 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. ..... 19....

20-UNDERTAKER. Commissioner Health. ADDRESS

MAY 1-1923

Per Wm. H. WOOBALL

Instructions on back of certificate.

UNIVERSITY OF MARYLAND.

Baltimore, Maryland., April 29, 1924.

of deceased
I do hereby make oath that the name/given on Baltimore City Health Department Certificate of Death - D -75378 as John Shanks, is not correct; the correct name of the party is Emil Schunk. Date of death April 28, 1923.

George Schunk
Brother.

Subscribed and sworn to before me this 29th day of April, 1924.

Reed Gaither
Notary Public.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75379

CERTIFICATE OF DEATH.

41

D75379

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospl ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Loretta Ayres

(a) RESIDENCE NO. 1306 Wilson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Abram Ayres

6 DATE OF BIRTH (month, day, and year) Dec 30-1892

7 AGE — Years	Months	Days	If LESS than 1 day, hrs. or min.
30	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank McClain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Minnie Wamberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Abram Ayres

(Address) 1306 Wilson St

15 Filed 1-1923 , 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923. to April 30. 1923. that I last saw h alive on April 30, 1923, and that death occurred, on the date stated above, at 4.05 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Staphylococcic Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No P. S. & S.

What test confirmed diagnosis?

(Signed) John G. Unger, M. D.

, 19 (Address) St. Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cook Town Md

DATE OF BURIAL May 1923

20 UNDERTAKER H C Mudd

ADDRESS Greenmount Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should give name of infectious disease, if any, which may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75380

CERTIFICATE OF DEATH. X 101-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brooks

(a) Residence No. 206 S. Bethel St. St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1881

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 40

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Washington, D.C.

PARENTS.

10-NAME OF FATHER, John Brooks

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, Francis Poindexter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 30, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 26 1923 to April 30 1923

that I last saw him alive on April 29 1923,

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes Autopsy

What test confirmed diagnosis?

(Signed) J. A. McKay M. D

5-30-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Washington D.C.	May 1, 1923
20-UNDERTAKER.	ADDRESS
W. J. Ticknor & Son	North & Penna Ave

Instructions on back of certificates.

pec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75381 — CERTIFICATE OF DEATH. 25-001 — D75381

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 704 S Broadway St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dombrawski jr

(a) Residence No. 704 S Broadway St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) X

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 8 1922

7-AGE. ....yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Boy

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. James Dombrawski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Xsevera Janczak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Jam Dombrawski

(Address) 704 S Broadway

15- [illegible] E. GRIFFITH,

[illegible] 19.. Registrar.

1-1923 Burial Permit Clerk

instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 1 1923

17- I HEREBY CERTIFY, That I attended deceased from Apr 27 1923 to May 1st 1923

that I last saw him alive on May 1st 1923,

and that death occurred, on the date stated above, at 930 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Infected Scalp

(Duration) ....yrs. ....mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A Hass, M. D.

May 10, 1923 (Address) 24 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary — DATE OF BURIAL. May 2 1923

20-UNDERTAKER. John McAleer — ADDRESS 1803 Bank St

Spec. 1-10-21 MAT 1500 Blks.

D75382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75382

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Homewood Hosp. St., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy M. Reese

(a) RESIDENCE No. 118-E 24th St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Elizabeth Reese

6 DATE OF BIRTH (month, day, and year) 1849-7-25

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	73	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Solicitor

(b) General nature of industry, business, or establishment in which employed (or employer) Mercantile

(c) Name of employer Trust & Dep. Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Hollowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Guy A. Reese (Address) 405 Bretton Pl.

15 Filed 1923 Robert F. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH Apr. 30

16 DATE OF DEATH (month, day, and year) Apr. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28, 1923, to Apr. 30, 1923, that I last saw h[e] alive on Apr. 30, 1923, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobal.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Flora C. Clark, M. D.

May 1, 1923 (Address) 2 Fifth Apt. Charlesgate

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	5-2 1923
20 UNDERTAKER Percy W. Jenkins & Sons Co.	ADDRESS McCulloh & Orchard

TION is very important. See instructions on back of certificates.

D75383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75383

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. St. Joseph's Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cyril Osmond

(Residence in Baltimore: No. 1111 Barclay St. (yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: white male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH: July 20/1920 (Month) (Day) (Year)

7-AGE: 2 yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Penna.

PARENTS:

10-NAME OF FATHER: Alexander W Osmond

11-BIRTHPLACE OF FATHER, (State or Country): England

12-MAIDEN NAME OF MOTHER: Lillian Thomas

13-BIRTHPLACE OF MOTHER, (State or Country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alex. W. Thomas

(Address) 1111 barclay

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Crushed pelvis- Frac... left leg and arm. (struck by Shock - hemorrhage automobile)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Collins M. D. (Coroner)

5/1/23 192.... (Address) 508 E. Noth Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May 3 1923

20-UNDERTAKER: Wilbur H. Shriver — ADDRESS: 1018 Edmondson Ave

If very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75384

D75384

CERTIFICATE OF DEATH.

117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George P. Dorsey

(a) RESIDENCE NO. 1727 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Dorsey

6 DATE OF BIRTH (month, day, and year) Jan 11- 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardware

(b) General nature of industry, business, or establishment in which employed (or employer) United Electric Railways

(c) Name of employer Balto. Md

9 BIRTHPLACE (city or town) (State or country) Geo. Dorsey

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Minnie Dorsey (Address) 1727 E. Biddle

15 1-1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1. 1923

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1923 to May 1, 1923.

that I last saw him alive on May 1, 1923.

and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos ~~ds.~~

CONTRIBUTORY (Secondary) Appendicitis + Seminal Vesiculitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 26-23

Was there an autopsy? No

What test confirmed diagnosis? P. S. S. - Operation

(Signed) Harold C. Pillsbury M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery DATE OF BURIAL May 4 1923

UNDERTAKER F. O'B Kilpatrick & Son ADDRESS Fred'k

TION is very important See instructions on back of certificates. Exact statement of OCCUPA- that it may be properly classified.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75385

CERTIFICATE OF DEATH.

D75385

1-PLACE OF DEATH Maryland General Hospital 18 135

CITY OF BALTIMORE: (No. ..... St., ... Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Stehle

(a) RESIDENCE No. 1125 N. Saratoga St., ... Ward .....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Stehle

6 DATE OF BIRTH (month, day, and year): April 2-1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
70	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

1888

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Peter Stehle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Kate Stehle 1129 N. Saratoga St.

15 Filed 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to April 30, 1923,

that I last saw him alive on April 30, 1923,

and that death occurred, on the date stated above, at 3.15 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Est home April 12-23

Did an operation precede death? Yes Date of April 20-23

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) James A. Wilkinson, M. D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 2 1923

20 UNDERTAKER: F. S. Kippert — ADDRESS: 2256 Frederick Ave

Burial Permit Clerk.

1. D75385

1. PLACE OF DEATH. (If death occurred in a hospital or institution, give its NAME instead of street and number.) CITY OF BALTIMORE: (No. ..... St., ... Ward) Maryland General Hospital

2. FULL NAME Peter Stehle

(a) RESIDENCE No. 1125 N. Saratoga St., ... Ward .....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced, (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Stehle

6. DATE OF BIRTH (month, day, and year): April 2-1853

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
70	—	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

1888

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER: Peter Stehle

11. BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14. Informant (Address): Kate Stehle 1129 N. Saratoga St.

15. Filed 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year): April 30 1923

17. I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to April 30, 1923,

that I last saw him alive on April 30, 1923,

and that death occurred, on the date stated above, at 3.15 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted If not at place of death? Est home April 12-23

Did an operation precede death? Yes Date of April 20-23

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) James A. Wilkinson, M. D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 2 1923

20. UNDERTAKER: F. S. Kippert — ADDRESS: 2256 Frederick Ave

Burial Permit Clerk.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Name of property classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75386 D75386

CERTIFICATE OF DEATH.

102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5342 Park Heights Ave ST. 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen McDorman Ford

(a) RESIDENCE NO. 5342 Park Heights ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Wesley Ford.

6 DATE OF BIRTH (month, day, and year): July 7 1845

7 AGE — Years: 77 Months: 9 Days: 21 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Tubman White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Walston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Julian A. Childs (Address) 5342 Park Heights Ave

15 Filed May 1 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1923, to May 1, 1923, that I last saw h[illegible] alive on Apr 27, 1923, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

four hours.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pleurisy with effusion 4 days

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) McBaumand Ford, M. D.

May 1. 1923 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: May 3 1923

20 UNDERTAKER: Wm Tuckers Son — ADDRESS: Norfolk Va

TION is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Dr. M. Bowman Hood,
626 N. Kilmer

Spec.—1-10-21—M&T—1500 Blks.

D75387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75387

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Watson

(a) RESIDENCE NO. 253 N Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alex. Watson

6 DATE OF BIRTH (month, day, and year) Dec 17-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John W. Mitchell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Georgeanna Hyde

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant E. Warden Pitsken
(Address) Charleston W. Va

15 Filed , 19 Robert P. Harrison, Registrar

1-1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27th 1923, to May 1st, 1923, that I last saw her alive on May 1st, 1923, and that death occurred, on the date stated above, at 2-30 P m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination & Symptoms

(Signed) Hal Hargrave, M. D.

, 19 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Millersville, Md	May 3 1923
UNDERTAKER Wm J Tickner & Son	ADDRESS N & Pan

TION is very important. See instructions on back of certificates. Exact statement of ... may be properly classified. ...

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75388

CERTIFICATE OF DEATH. 118-001

D75388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred C. Joyce

(a) RESIDENCE No. 708 N. Kenwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Alfred C. Joyce

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Joyce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Erick Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 23 1923 to Apr 30 1923 that I last saw h[illegible] alive on May 1 1923 and that death occurred, on the date stated above, at 1 00 A m.

The CAUSE OF DEATH* was as follows:

Right Femoral hernia with omentocele & hydrocele

(duration) 11 yrs. — mns — ds.

CONTRIBUTORY (Secondary) Myocarditis; paralytic ileus

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/25/23

Was there an autopsy? No

What test confirmed diagnosis? Operation & Clinical findings

(Signed) G. C. Hailey M. D.

Apr. 1923 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL May 3 1923

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS North & Penna Ave

TION is very important. See instructions on back of certificates. Exact statement of [illegible] may be properly classified.

Spec.—1-10-21—MAT—1500 Nbs.

D75389

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75389

CERTIFICATE OF DEATH.

W. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2411 Franklin St. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Muriel Enid Jones

(a) RESIDENCE No. 2411 Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Gilbert Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sadie Dent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Gilbert Jones
(Address) 2411 Franklin St

15 Filed MAY 2-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to April 30, 192..., that I last saw her alive on April 30, 1923, and that death occurred, on the date stated above, at 8-30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneaumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-2-1923
20 UNDERTAKER Daniel Easton	ADDRESS Same

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as "ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75390

CERTIFICATE OF DEATH.

31

D75390

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 West Hoee St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Walter Day

(a) Residence No..... 125 W. Hoee St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 21, 1910

7-AGE.	If LESS than 1 day.
12 yrs. 8 mos. 8 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Richmond
(State or Country)..... Virginia

PARENTS.

10-NAME OF FATHER, Harry Day

11-BIRTHPLACE OF FATHER (city or town) Richmond
(State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary Bolbitt

13-BIRTHPLACE OF MOTHER (city or town) Giston
(State or Country), N.C.

14- (Informant) Arthur Bolbitt (uncle)

(Address) 125 W. Hoee St.

15- Filed MAY 2-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 29, 1923.

17- I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1923, to April 29, 1923,

that I last saw him alive on April 28, 1923,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. 17 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D.H. Carroll M. D.

5/11, 1923 (Address) 140 Whitehall St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mount Auburn	May 2, 1923

20-UNDERTAKER,	ADDRESS
John H. Frazier	1021 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75391

CERTIFICATE OF DEATH.

D75391

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 N. Bond ST.; 6 WARD) 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louvinia Henson

(Residence in Baltimore: No. 306 N Bond St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ? (Month) ? (Day) about 1855 (Year)

7-AGE, About 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Henson (Husband)

(Address) 306 N Bond St

15- MAY 2 - 1923 Filed....., 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 29 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 10 1923, to April 29 1923, that I saw her alive on April 28 1923, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nephritis

Secondary Valvular

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) R. J. Young M. D.

4/30, 1923 (Address) 1129 Monument

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, 5/2, 1923

20-UNDERTAKER Wm J. G. Locks ADDRESS 1302 Jeffers

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75392
1-PLACE OF DEATH

CERTIFICATE OF DEATH. 1923 00.3

D75392
Registered No. C.....

City of BALTIMORE: (No. Church Home Infirmary St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florian Borkowicz

(Residence in Baltimore: No. 1014 S. East Ave St. / yrs. 6 / mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	single

6-DATE OF BIRTH, Aug. 3/1915
(Month) (Day) (Year)

7-AGE, 6 yrs. 8 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: school boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Borkowicz

11-BIRTHPLACE OF FATHER, (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Rosalia Zapolowicz

13-BIRTHPLACE OF MOTHER, (State or Country), Chicago Ill

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Borkowicz

(Address) 1014 SS East Ave

15- Filed MAY 2 - 1923. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30/23, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- struck by auto truck
Crushed skull- fractured clavicle
lacerated rt. leg

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Pollen M. D.
(Coroner)

5/1/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus	May 3 1923

20-UNDERTAKER	ADDRESS
Stephen J. Kwiatkowski	1008 S Kenwood

(Instructions on back of certificate.)

Spec. 1-10-21 MA 1 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75393
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

1101-001 D75393
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 750 Vine ST., 4 WARD)

2-FULL NAME Wm H Travers

(a) RESIDENCE NO. 750 Vine ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) box Maker
(c) Name of employer Sharp & Dohme

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John E Travers
11 BIRTHPLACE OF FATHER (city or town) "C. Shore"
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Burg
13 BIRTHPLACE OF MOTHER (city or town) Hausbury md
(State or country)

14 Informant Wilbert Travers
(Address) 750 Vine St

15 MAY 2-1923 ROBERT N. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Ap 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Ap 28, 1923 to Ap 30, 1923.
that I last saw h[illegible] alive on Ap 30, 1923.
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(duration) 0 yrs. 0 mos 9 ds.

CONTRIBUTORY (Secondary) None
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis? Clinical signs
(Signed) R B Henson M. D.
May 1923 (Address) 601 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn ct — DATE OF BURIAL May 4 1923

20 UNDERTAKER J. R. Brown and Son — ADDRESS 105 W Mt

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

Vaishnis

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75394

CERTIFICATE OF DEATH.

44 D75394

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 S. Paca ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Vaishnis

(a) RESIDENCE. NO. 415 S. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~Wife of~~) Christine

6 DATE OF BIRTH (month, day, and year) Dec. 26, 1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
67	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant V. Vaishnis

(Address) 415 S Paca Street

15 MAY 2-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 . 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1923, to May 1, 1923, that I last saw him alive on May 1, 1923, and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the cardiac end of the Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronnshan, M. D.

(Address) 618 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
new Cathedral cem	May 4, 1923

20 UNDERTAKER ADDRESS

John Grabianska 426 S. Poca St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75395 HEALTH DEPARTMENT—CITY OF BALTIMORE D75395

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2904 Brighton ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Collins

(a) RESIDENCE NO. 2904 Brighton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Grace Collins

6 DATE OF BIRTH (month, day, and year) December 10th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City

(c) Name of employer water department

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER William Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Margaret Collins

(Address) 2904 Brighton St.

15 MAY 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1923, to May 1, 1923,

that I last saw h alive on April 25, 1923,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Norwood M. D.

May 2, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	May 3rd 1923
20 UNDERTAKER	ADDRESS
John F. Cowan & Son	901 Hollins St.
per F. F. Cowan	

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...ch may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D75396

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2146 W Lexington ST. 23 WARD)

2-FULL NAME Mary Frances Willen

(a) RESIDENCE. No. 1424 Patapsco ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Willen

6 DATE OF BIRTH (month, day, and year) Nov. 2 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Talbert

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine Rigbon

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Maryland

14 Informant Mrs Earl Selberg
(Address) 1424 Patapsco St.

15 Filed ..... 19 MAY 2-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11th, 1923, to Apl. 30, 1923, that I last saw h W alive on Apr. 29th, 1923, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chr. Valvular Disease of Heart

Chr. Myocarditis (duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wash E. Kemp, M. D.

19 (Address) 1013 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 3 1923
20 UNDERTAKER	ADDRESS
Henry Lutz	1203 N. Broadway

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- be properly classified, so that it may be should state

D75397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75397

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert E. Huber

(Residence in Baltimore: No. 3107 Dillon St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	single

6-DATE OF BIRTH. June 8/1920 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
2 yrs. 10 mos. 23 ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Paul H. Huber

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Catherine M. Wolfe

13-BIRTHPLACE OF MOTHER. (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Zirkler & Zirkler

(Address) 1739 Eager st

15-

FILED MAY 2 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 1st/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Scarlatina

(Autopsy at Hospital)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Bruce M. D. (Coroner.)

5/2/23 192.... (Address) 508 E. North Ave.....

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel	May 2 1923
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1739 Eager

Duplicate.

Important: See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75398

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75398

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5301 York Rd. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis. Wise Sumam.

(a) RESIDENCE. No. 5301 York Rd. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of
(~~or WIFE of~~) Cora L. Sumam

6 DATE OF BIRTH (month, day, and year) March 2 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Funkenbaugh-Bulk & Co

9 BIRTHPLACE (city or town) Frederick
(State or country) Md.

PARENTS

10 NAME OF FATHER Isreal W. Sumam

11 BIRTHPLACE OF FATHER (city or town) Frederick
(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline E. Wise.

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country) Md.

14 Informant Cora L. Sumam
(Address) 5301 York Road.

15 Filed MAY 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19 - 1923, to May - 1 - 1923,
that I last saw him alive on April 30 - 1923,
and that death occurred, on the date stated above, at 12 10 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Hoen, M. D.

4-1, 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md. —	May - 4 - 1923

20 UNDERTAKER Wm. Cooke - ADDRESS 502 E. North Ave.

IMPORTANT. Give instructions on back of certificates. ... CAUSE OF DEATH, NATIVITY, OCCUPA-

Spec.—1-10-21—MAT—1500 Blks.

D75399 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 129 D75399

1-PLACE OF DEATH

REGISTERED NO.

(If death occufred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 28 Bond ST., 24 WARD)

2-FULL NAME William H Gambrill

(a) RESIDENCE NO. 1528 Byrd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura F

6 DATE OF BIRTH (month, day, and year) Aug 15 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John Gambrill

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Dorit Kemp

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co
(State or country)

14 Informant Mrs Geo F Thomas
(Address) 1525 Bond St

15 Filed MAY 2 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 11 1923 to May 1 1923,
that I last saw him alive on May 1 1923,
and that death occurred, on the date stated above, at 7 15 a m.
The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

unknown
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy

(Signed) Wm E Ziegler, M. D.

5/2 1923 (Address) 1019 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill May 5 1923

DATE OF BURIAL

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified, so that it ma

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75400

CERTIFICATE OF DEATH.

101-001

D75400

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Gibbons Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alathe E Griffin

(a) RESIDENCE. No. 18 Gibbons Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER James P Jenkins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Delphena Lee

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Mary L Schaefer

(Address) 18 W Gibbons Ave

Filed MAY 2 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1923

17

I HEREBY CERTIFY, That I attended deceased from April 15 1923 to May 1 1923

that I last saw her alive on May 1 1923

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J F Crosthans M. D.

May 1 1923 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Louis Cemetery Howard Co Md	May 3 1923
20 UNDERTAKER	ADDRESS
Scott W Storr	Edmondson

TION is very important. See instructions on back of certificates.

that it may be properly classified. Exact statement of OCCUPA-

D75401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1855

D75401

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H Webb

(Residence in Baltimore: No. 717 W Lombard St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word)
Male	White	Single

6-DATE OF BIRTH, Feb (Month) 4 (Day), 1877 (Year)

7-AGE, 46 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Helper
(b) General nature of industry, business, or establishment in which employed (or employer): Moving Van

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John H Webb

11-BIRTHPLACE OF FATHER (State or Country), Frederick Co Md

12-MAIDEN NAME OF MOTHER Emma J Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Webb

(Address) 2445 W Balto. City

15- Filed MAY 2-1923 ROBERT R. KRAUTER, Registrar of Vital Statistics.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of Skull Instant Cause — Man was standing Still) he fell down from Fall from moving Van (Duration) yrs. mos. 2 hrs.

CONTRIBUTORY (Secondary) Hypertrophy of Heart Chronic Nephritis (Duration) yrs. mos. 3 hrs.

(Signed) James W Frost (Coroner.) M. D.

April 30 1923 Address 700 Chas

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? Fulton St Balto City

Former or usual residence 717 W Lombard St

19-PLACE OF BURIAL OR REMOVAL, W X Cem

DATE OF BURIAL, May 2 1923

20-UNDERTAKER John Sellner

ADDRESS 2007 Allen

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75402

CERTIFICATE OF DEATH.

D75402

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Patterson Pk Ave ST., 7 WARD)

2-FULL NAME Jesse DeBois Roland

(a) RESIDENCE No. 508 N. Patterson Pk Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Lillian Roland

6 DATE OF BIRTH (month, day, and year) July 4 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co Md

PARENTS

10 NAME OF FATHER Benjamin Roland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Martha DeBois

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant C. Clarence B. Roland (Address) 2514 Jefferson St

15 Filed MAY 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1923

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to April 30, 1923, that I last saw him alive on April 30, 1923, and that death occurred, on the date stated above, at 905 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion & acute Dilitation of Heart

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. D. Carman, M. D.

4-30 1923 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL May 3 1923

20 UNDERTAKER John Sellner — ADDRESS 2008 Eden

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75403 CERTIFICATE OF DEATH. 101-001 D75403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3160 Elmora ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Evelyn Raley

(a) RESIDENCE NO. 3160 Elmora ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph L. Raley.

6 DATE OF BIRTH (month, day, and year): Feb 14 1897

7 AGE: Years 25 Months 7 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Wm Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Daisy B Snodgrass

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Daisy Burgan (Address): 3160 Elmora

15 MAY 2-1923 ROBERT R. KRAUTER Burial Permit Clerk. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-30 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-14, 1923, to 4-30, 1923, that I last saw her alive on 4-29, 1923, and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus.
Meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Miller, M. D.

4/30/23 (Address) 2737 W. Mosher ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: May 2 1923

20 UNDERTAKER: John Sullivan — ADDRESS: 2000 Pulaski

FROM IS very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75404 — CERTIFICATE OF DEATH. — 117 — D75404

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE (No. ..... ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Tapper

(a) RESIDENCE NO. 1515 Gough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 28-1911

7 AGE — Years: 11 — Months: 9 — Days: 4 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DE[redacted]

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jos Tapper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Lena Berkowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address): 1439 E Balto St

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
MAY 2-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 19 23

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to May 1, 1923.

That I last saw h/M alive on May 1, 1923

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Shock

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Ruptured appendix & peritonitis - intest obstruction (duration) 15 days yrs. ..... mos. ..... 5 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes (3) Date of 4/15/23

Was there an autopsy? Yes Date of 5/1/23

What test confirmed diagnosis?

(Signed) Walter Sondheimer, M. D.

19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 5/2 19 23

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ... may be properly classified.

D75405

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75405

CERTIFICATE OF DEATH.

100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 N. Dallas St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Raitzyk

(Residence in Baltimore: No. 911 N. Dallas St, Life yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	S[illegible]

6-DATE OF BIRTH. March 7/23 1.....
(Month) (Day) (Year)

7-AGE. ....yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which emp' yed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Sol Raitzyk

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. Leah McKenna

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sol Raitzyk

(Address) 911 N. Dallas

15-

Filed MAY 2-1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clark

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1/23, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) yrs. 1 mos. ....ds.

(Signed) J S H Cullen M. D.
(Coroner.)

5/2/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Kehren Herring Run DATE OF BURIAL. 5/4 1923

20-UNDERTAKER. Jack Leuro ADDRESS 1439 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75406

D75406

CERTIFICATE OF DEATH.

7H-001

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1379 N Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmina E Watkins

(Residence in Baltimore: No. 1379 N Carey St.; 1 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Dec (Month) (Day) 1844 (Year)

7-AGE. 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Curtis Dorsey

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Rachel McLaughlin

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Bailey

(Address) 1379 N Carey

15 MAY 2 - 1923 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Clerk.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 29, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1923, to April 29 1923, that I saw h alive on April 27 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. mos. ds.

(Signed) H S McCardell M. D.

4/30, 1923 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn

DATE OF BURIAL. 5/5/23

20-UNDERTAKER Samuel Kennedy

ADDRESS 328 Eddy

Spec.—1-10-21—M&T—1500 Bks.

Scharffe.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75407

CERTIFICATE OF DEATH.

90 D75407

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 E Getting ST., 27 WARD)

2-FULL NAME Conrad. Stummer

(a) RESIDENCE NO. 132 E Getting ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary. Stummer

6 DATE OF BIRTH (month, day, and year) Nov 9 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Michael. Stummer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary Stummer

(Address) 132 E Getting St

15 Filed ... 19 ... Registrar

GILBERT R. KRAULER. MAY 2-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 , 1921 , to May 1st , 1923 .

that I last saw him alive on April 25 , 1923 ,

and that death occurred, on the date stated above, at 8.25 - m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis - Chronic -

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) G E Burton, M. D.

5/1/1923 (Address) 301 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL 5-4-1923

20 UNDERTAKER Ehrb Hahn

ADDRESS 115 E West St

NOTE—It is very important. See instructions on back of certificates. Exact statement of OCCUPA-

(Martin B. Richardson) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75408 D75408

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 N. Fremont ave ST. 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin B. Richardson

(a) RESIDENCE. No. 309 N. Fremont ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE~~ of) Lucy Richardson

6 DATE OF BIRTH (month, day, and year) Nov. 25-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Alex. Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Sydney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lucy Richardson (Wife)
(Address) 309 N. Fremont Ave

15 Filed ..... 19 MAY 2-1923

HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to April 28, 1923, that I last saw h[illegible] alive on April 28, 1923, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis Observation by Physician

(Signed) [illegible] M. D.

19[illegible] (Address) 712 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 2 1923
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1309 Druid Hill Ave

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75409

CERTIFICATE OF DEATH.

MH-001 D75409

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

2-FULL NAME Joseph Maguire-

(a) RESIDENCE. NO. Mount Hope Retreat ST. 28th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred over 30 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Maguire

6 DATE OF BIRTH (month, day, and year) 3-2-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt	72	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md-

PARENTS

10 NAME OF FATHER Christian P. Maguire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susanna Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Frank J. Maguire 2518 Eutaw St.

15 Filed 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1923, to May 1 1923, that I last saw him alive on May 1, 1923, and that death occurred, on the date stated above, at 9.10. P m.

The CAUSE OF DEATH* was as follows:

Paralysis- Post Cerebral Hemorrhage

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Chr. Organic Psychosis.

over (duration) 30 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	5/3 1923

20 UNDERTAKER Martin Kelly & Son ADDRESS 1827 W North

Sec. 3 Chap. 487 Laws of Maryland, 1898. See instructions on back of certificates.

Spec.—6-2-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75410

CERTIFICATE OF DEATH.

90 D75410

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Drury

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? —— yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mrs Drury

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	90	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Excavator.

(b) General nature of industry, business, or establishment in which employed (or employer) Excavating Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dubuke Iowa.

PARENTS

10 NAME OF FATHER Andrew Flemm.

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) France

12 MAIDEN NAME OF MOTHER Catherine Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emmitsburg. Md.

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Balto Md

15 Filed 19 Robert P. Harrison, Registrar

-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 29th, 1920, to May 7, 1923, that I last saw h... alive on May ..., 1923, and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Val. (Mitral) Disease of Heart -

one (duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis.

one (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Southern Cathedral	5/4 1923

20 UNDERTAKER Martin Lahey & Son ADDRESS 1827 N North

See instructions on back of certificates. Exact statement of OCCUPA...

Spec.—1-10-21—M&T—1500 Bks.

D75411

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75411

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2515 Salem Av. ST., 13 WARD)

2-FULL NAME Lula. May. Thomas. Coleman

(a) RESIDENCE NO. 2515 Salem Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 17/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3 year			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Amilia Kehran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Thomas Coleman
(Address) 2515 Salem Av.

15 5/11-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1923. to April 30. 1923.
that I last saw h alive on April 30, 1923.
and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? .....

(Signed) John D. Quinn, M. D.

(Address) 1507 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	May 2 1923

20 UNDERTAKER ADDRESS

George F. Rutt 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Bks. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Property, Cashier.

Form 12-23-21—E B P S—400 Blks.

D75412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-00 D75412

Registered No.....

1-PLACE OF DEATH Plaza Apartments

City of BALTIMORE: (No. Park Ave & Wilson St. 814 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth F. Frank

(a) Residence No. Park Ave & Wilson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Chas F. Frank

6-DATE OF BIRTH (month, day and year) May 12 1863

7-AGE. 59 yrs. 11 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Josiah Waters

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Margaret Lambert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

11- (Informant) Chas. A. Frank

(Address) Park Ave & Wilson Sts

15- 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 2 192

17. I HEREBY CERTIFY, That I attended deceased from April 27th 1923 to May 2nd 1923

That I last saw h. alive on May 1st 1923

and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Influenza).

(Duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insuffic.

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Chas. E. Hubbard M. D.

, 19 (Address) 315 W. Royal Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown Pa

DATE OF BURIAL. May 3 19

20-UNDERTAKER. Josiah Syfer

ADDRESS 16 or 18 N. Wolfe ave

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75413

CERTIFICATE OF DEATH.

101-001 D:5413

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Mt. Royal Avenue ST., 11 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Riordan

(a) RESIDENCE No. 1301 Mt. Royal Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Storck

6 DATE OF BIRTH (month, day, and year) July 24, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Export Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Timothy Riordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William A. Riordan (Address) 1301 Mt. Royal Ave.

15 Filed ..., 19... Robert P. Harrison, Registrar

1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1- 1923

17

I HEREBY CERTIFY, That I attended deceased from 4-29, 1923, to 5-1, 1923.

that I last saw h[illegible] alive on 5-1, 1923,

and that death occurred, on the date stated above, at 1.05 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Dorsey, M. D.

, 19 (Address) 1008 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/ 3 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Note—It is very important. See instructions on back of certificates. Exact statement of [illegible]

Spec.—1-10-21—M&T—1500 Blks.

D75414

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75414

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 E. 20th St. ST. 12 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander C. Finn

(a) RESIDENCE No. 720 E. 20th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia M. Finn

6 DATE OF BIRTH (month, day, and year) Oct., 11-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jno. Finn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Julia Finn (Address) 720 E. 20th St.

15 2-1923 Robert P. Harrison, M. D. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1922, to April 30, 1923, that I last saw him alive on April 30, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam of specimen

(Signed) Robt J Grimm M. D.

5-1, 1923 (Address) 120 August St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/3 1923

20 UNDERTAKER Chas. F. Evans & Son-118 W. Mt Royal Ave.

ADDRESS

FROM is very important. See instructions on back of certificates. Exact statement of ... is ... property classified. ... may be ...

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75415

CERTIFICATE OF DEATH.

74-001 D75415

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 E. Hoffman St. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Gaffey

(a) RESIDENCE No. 1427 E. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William J. Gaffey

6 DATE OF BIRTH (month, day, and year) May. 2-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At. Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Jos. Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget McGovern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William J. Gaffey (Address) 1427 E. Hoffman St.

15 Filed 2-1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1923

17

I HEREBY CERTIFY, That I attended deceased from acute 2 greeks. to , 19 23

that I last saw h 2 alive on Apr. 28 , 19 23,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

2 wks (duration) Cerebral hemorrhage

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? none Date of

Was there an autopsy? no

What test confirmed diagnosis? — use

(Signed) [illegible] M. D.

4/30 19 23 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	5/3/23

20 UNDERTAKER ADDRESS

Chas. F. Evans & Son, 118 W. Mt Royal Ave.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION CAUSING DEATH is very important.

Spec.—1-10-21—M&T—1500 Blks.

D75416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131

D75416

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 S. Charles St., 11 WARD)

2-FULL NAME Florence A. Stevens

(a) RESIDENCE NO. 1029 S. Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. E. Stevens

6 DATE OF BIRTH (month, day, and year): Sept 20, 1857

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Charles Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mollie Granger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Thos. E. Stevens 1029 S. Charles

15 Filed 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922 to May 2, 1923.

that I last saw her alive on May 1, 1923.

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lungs

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Fred D Jewett, M. D.

(Address) 2516 Penna. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: May 5 1923

20 UNDERTAKER: Wm Cook

ADDRESS: Sole Work

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75417

CERTIFICATE OF DEATH.

X 57

D75417

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jose Ignacio Chopitea

(a) RESIDENCE NO. Lima, Peru ST., ... WARD ~~Baltimore~~ Peru

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? 3 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Fortunata H. de Chopitea

6 DATE OF BIRTH (month, day, and year) Aug 23, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Trugillo, Peru

PARENTS

10 NAME OF FATHER Manuel A. Chopitea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trugillo, Peru

12 MAIDEN NAME OF MOTHER Dolores L. Victoria

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Trugillo, Peru

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 Filed ..... 19 ..... Robert P. Garrison, Registrar

1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to May 1, 1923, that I last saw h[illegible] alive on May 1, 1923 and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

following pleural pneumonectomy

(duration) ..... yrs. ..... mos 9 hours ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Peru

Did an operation precede death? Yes Date of April 30, 1923

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Winfield W. Scott M. D.

, 1923 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City	May 3rd 1923
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Son & Co	Oxford & Lucas Sts.

TION is very important. See instructions on b[illegible] of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75418 D75418

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 E. North Ave ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Missiana Rosston

(a) RESIDENCE No. 143 E. North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Harry B Rosston

6 DATE OF BIRTH (month, day, and year): May 21 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Louis L. Walcox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Martha E. Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn Pa

14 Informant: Harry B Rosston

(Address): ~~Same~~ 143 E North Ave

15 Filed 19 Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1 1923

17

I HEREBY CERTIFY, That I attended deceased from April 29 1923. to May 1 1923.

that I last saw h~~er~~ alive on April 30 1923.

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hom

(Signed) Hubert C Knapp, M. D.

May 19 23 Address 1216 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 4 1923
20 UNDERTAKER	ADDRESS
Murphy Jenkins & Sons Co	Preston & Eden Sts

This is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75419

CERTIFICATE OF DEATH.

11-001

D75419

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 E. Bartlett ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Sinnott

(a) RESIDENCE NO. 700 E. Bartlett ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget Sinnott

6 DATE OF BIRTH (month, day, and year) Mar 17-1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Cattle Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Sinnott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Alice Pitzpatrick (Address) 700 E. Bartlett St.

Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from April 12th, 1923, to April 30th, 1923, that I last saw him alive on April 30th, 1923, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Grip

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 700 E. Bartlett St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm Conrad Bode, M. D.

1923 (Address) 1900 Maryland ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery	5/3/1923
20 UNDERTAKER J. J. Moran	ADDRESS 300 E Balto St.

Instructions on back of certificates. Exact statement of occupation very important.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75420

CERTIFICATE OF DEATH.

91-002

D75420

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 E. Chase ST., 11th WARD)

2-FULL NAME Wilhelmine Hannickel O'Donnell

(a) RESIDENCE No. 210 E. Chase ST., 11th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. O'Donnell

6 DATE OF BIRTH (month, day, and year) June 2 1829

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	93	11	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hanau Germany

PARENTS

10 NAME OF FATHER Heinrich Hannickel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Faber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant C. Sanchez Boone

(Address) 210 E Chase St.

15 Filed ..... 1923 ....., 19.....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to May 2, 1923, that I last saw h alive on May 1, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Kidneys (old age)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emory B Grinnalds M. D.

, 1923 (Address) 26 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — London Park Cem — DATE OF BURIAL May 4 1923

20 UNDERTAKER H H Eakin & Son — ADDRESS Cor Laf & Mt Royal

Exact statement of OCCUPA-

Items are very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75421

1632 Rud

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75421

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

JOHNS HOPKINS HOSPITAL

2-FULL NAME Josephine Konopaunk

(a) RESIDENCE NO. Turners Station Md ST., ... WARD Turners Sta-Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-18-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Michael Konopaunk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Kotkainck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Turners Sta

15 Filed ..... 19 1923 Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2- 1923

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to May 2, 1923, that I last saw her alive on May 2, 1923, and that death occurred, on the date stated above, at 4.15 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. Life mos. ..... ds.

CONTRIBUTORY (Secondary) Primary

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. A. Weech, M. D.

. 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cemetery — DATE OF BURIAL: May 3 23

20 UNDERTAKER H. E. Stuckey — ADDRESS 424 N. Broadway

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75422

D75422

CERTIFICATE OF DEATH.

45

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3816 Lloyd Ave. ST.: 28 WARD)

2-FULL NAME John Ingles Figg

(a) RESIDENCE. No. 3816 Lloyd Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Allen Figg

6 DATE OF BIRTH (month, day, and year) Jan 24, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER James Figg.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Miss Ingles.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Mrs John Evans.

(Address) 3816 Lloyd Ave.

15 Filed ..... 19..... ROBERT R. KRAUTER, Burial Permit Clerk.

MAY 3-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1922, to May 1st, 1923, that I last saw h[illegible] alive on May 1st, 1923, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of large bowel - (Carcinoma of sigmoid)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None -

(Signed) Harry S. McCarty, M. D.

5-3. 1923 (Address) 37 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	My. 4. 1923
20 UNDERTAKER	ADDRESS
C. L. McCormick	508 Linden Av.

Be sure that all items are properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Albrecht

(a) RESIDENCE NO. 1006 Brentwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 29-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER W. J. Albrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Margaret McCluskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant W. J. Albrecht

(Address) 1006 Brentwood Av

15 Filed MAY 3 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to May 2, 1923,

that I last saw him alive on May 2, 1923,

and that death occurred, on the date stated above, at 10:00 A.m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) — yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Measles.

(duration) — yrs. — mos. 16 ds.

18 Where was disease contracted if not at place of death? at St. Vincents

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B MacGowan, M. D.

5/3/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	5/3. 1923
20 UNDERTAKER	ADDRESS
Jos. Gemmit & Carroll	1003 Eastern

Item is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75424

CERTIFICATE OF DEATH.

181-003

D75424

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 28 WARD)

2-FULL NAME Charles Thomas Pound

(a) RESIDENCE NO. Ten Hills, Baltimore Co. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 9th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. John C. Pound

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Bertha Costello

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Dr. C. Pound
(Address) Ten Hills

15 Filed MAY 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1923, to May 2nd, 1923,

that I last saw him alive on May 2nd, 1923,

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure, under anaesthesia

(duration) instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary) Hare lip & cleft Palate

(duration) 2 yrs. 11 mos. 23 ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? Yes Date of May 2nd.

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [signature], M. D.

May 3rd, 1923 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL May 4 1923

20 UNDERTAKER [illegible] — ADDRESS [illegible]

(over)

Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1800 Blks.

D75425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75425

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Charles H. Starke

(a) RESIDENCE NO. Edgewood Md. ST., ... WARD Havre de Grace Harford Co. Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Miranda Everett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. G. Steely

(Address) Edgewood Md.

15 Filed MAY 3-1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1923, to May 2, 1923,

that I last saw him alive on May 2, 1923,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signature) James H. Wellington, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Christian Cem — DATE OF BURIAL May 3, 1923

20 UNDERTAKER Wm. Richardson — ADDRESS North Ave

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. It may be properly classified.

Allen

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75426

CERTIFICATE OF DEATH.

9 D75426

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 W. 4th York ST.: 22 WARD)

2-FULL NAME Harry Allen

(a) RESIDENCE. No. 110 W. 4th York ST., 22 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/24/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Estella Floyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Estella Floyd
(Address) 110 W. York St.

15 Filed MAY 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2/23

17 I HEREBY CERTIFY, That I attended deceased from 4/30/23, to 5/2/23, that I last saw him alive on 5/2/23, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

~~Influenza~~ Pneumonia
Broncho Pneumonia
(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Whooping Cough
Unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Worley M. D.

5/3/23 19 (Address) 908 S. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 3 1923

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Hanover

IMPORTANT.—Certificates may be properly classified. Exact statement of OCCUPATIONS should state very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75427

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D75427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1844 Division St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Holmes

(a) RESIDENCE NO. 1844 Division St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colord	Singl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13-19 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
		8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md

PARENTS

10 NAME OF FATHER Geo. Holmes

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va

12 MAIDEN NAME OF MOTHER Ella Turner

13 BIRTHPLACE OF MOTHER (city or town) St Mary's (State or country) md

14 Informant George Holmes (Address) 1844 Division St

Filed MAY 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1923, to May 2, 1923, that I last saw him alive on May 2, 1923, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Capillary Bronchitis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Ged Hall, M. D.

, 19 (Address) 426 E 23rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL May 5 1923

20 UNDERTAKER Mrs R a Elliott

ADDRESS 1725 Ashland Ave

FRONT IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75428
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

46 D75428

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3019 W Lath ave 15 WARD)

2-FULL NAME Clara F. Marrow

(a) RESIDENCE NO. 3019 W. Lath ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 1 mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) April 3/1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles F. Marrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Harietta Light

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary M Marrow

(Address) 3019 W Lath Ave

15 Filed MAY 3 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1922, to May 2, 1923, that I last saw her alive on May 1, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Sarcoma Uteris

(duration) yrs. 12 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas H Burbert. M. D.

, 19 (Address) 1100 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemy

DATE OF BURIAL May 4th 1923

20 UNDERTAKER Addie M Walker

ADDRESS 723 N Lafayette Ave

FROM is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75429

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ D75429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 McMechen ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma Streat

(a) RESIDENCE. No. 552 McMechen ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christopher Streat

6 DATE OF BIRTH (month, day, and year) Dec 30, 876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Keysville (State or country) Va

PARENTS

10 NAME OF FATHER Anthony Hawkins

11 BIRTHPLACE OF FATHER (city or town) Keysville (State or country) Va.

12 MAIDEN NAME OF MOTHER Ellen Crafton

13 BIRTHPLACE OF MOTHER (city or town) Keysville (State or country) Va

14 Informant Ellen Hawkins (Address) 552 McMechen St

15 MAY 3-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1923, to May 2, 1923, that I last saw h[er] alive on May 1, 1923, and that death occurred, on the date stated above, at 5.40 A. m.

The CAUSE OF DEATH* was as follows: 5.40 A.M.

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H Wright M. D.

May 2, 1923 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 4 1923
20 UNDERTAKER	ADDRESS
Hammett & Wright	864 N Carey St

Be very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75430

CERTIFICATE OF DEATH.

160 D75430

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2706 Fenwick St., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs John Sanders

(a) RESIDENCE NO. 2706 Fenwick St. 9 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary M Freund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) John Sanders 2706 Fenwick

15 Filed MAY 2 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923 to May 1, 1923

that I last saw h— alive on May 1, 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Suffocation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Clinically

Signed Wm. H. Campbell M. D.

May 2, 19 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 5/3/23 19

20 UNDERTAKER Geo. Weber, Son — ADDRESS 2503 Edmondson

Exact statement of OCCUPATION of property claimed. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75431

CERTIFICATE OF DEATH. 122-002 D75431

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vronica S. Hoch

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 0 mos. 23 ds. How long in U. S., if of foreign birth? [illegible] yrs. [illegible] mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Hoch

6 DATE OF BIRTH (month, day, and year) July 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46	47	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) (?) Germany

PARENTS

10 NAME OF FATHER Frederick Neubauer

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Germany

12 MAIDEN NAME OF MOTHER Vronica Neubauer

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Germany

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md -

15 MAY 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1923, to May 2, 1923, that I last saw h[illegible] alive on May 2, 1923, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver.

Abt 30 or 4 (duration) yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Manic Depr. Psychosis.

abt (duration) - yrs. 4 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 5 1923

20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1201 E Eager St

Important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

(Approved by U. S. Census and American Public Health Asso.)

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Alcoholic

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75432

CERTIFICATE OF DEATH.

129 D75432

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2544 Francis St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Minnie Helmrich

(a) Residence No. 2544 Francis st St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of late Richard Helmrich

6-DATE OF BIRTH (month, day and year) Sept 1-1846

7-AGE. 76 yrs. 8 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home nurse

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Kempskey

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Elizabeth White

(Address) 2534 Madison ave

15-

Filed MAY 3-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2-1923

17- I HEREBY CERTIFY, That I attended deceased from April 3, 1923 to May 2 1923

that I last saw her alive on May 1st 1923,

and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

Edema (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None save urinalysis.

(Signed) George Amos Bowden M. D

5/7 1923 (Address) 1517 E North Avenue

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loraine Cemetery

DATE OF BURIAL. May 4 1923

20-UNDERTAKER. Geo C. Miller

ADDRESS 2337 Jefferson

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75433 X10 D75433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Watson

(a) RESIDENCE NO. Note. (Just arrived in Balto) ST., WARD San Francisco Cal

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: cigarmaker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): San Francisco Cal

PARENTS

10 NAME OF FATHER Wm. Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Harry Watson San Francisco

15 MAY 3-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1923

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to April 30, 1923, that I last saw him alive on April 30, 1923, and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

Gangrene of lung

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Diphtheria, T, Ph + L.

(duration) — yrs. — mos. 18 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) [illegible] M. D.

5/1/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: San Francisco Cal

DATE OF BURIAL: May 3 23

UNDERTAKER: Robt J Turner Inc

ADDRESS: 1711 Pony

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- at it may be properly classified, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D75434 HEALTH DEPARTMENT—CITY OF BALTIMORE

99-00 D75434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 Gough ST., V WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose M. Miller

(a) RESIDENCE NO. 2028 Gough ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 4 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~and WIFE of~~ of John A. Miller

6 DATE OF BIRTH (month, day, and year) Nov 15-56

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John C. Schuh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md Ger.

12 MAIDEN NAME OF MOTHER: Wilhelmine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger

14 Informant (Address): John A. Miller 2028 Gough St

15 Filed MAY 3-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to May-1, 1923, that I last saw h-r alive on April 30, 1923 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac paralysis

(Duration)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Sub Acute Bronchitis

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Dr. E. Brune, M. D.

, 19 (Address) 125 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. DATE OF BURIAL: May 4-23

20 UNDERTAKER: Philip Herwig ADDRESS: 2016 Aliceanna

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D75435

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 Robert St. WARD) 14

2-FULL NAME Martha H. Brown

(a) RESIDENCE. No. 540 Robert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850.

7 AGE 72 Years 7 Months 25 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) a. a. Co Md

PARENTS

10 NAME OF FATHER John A. Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Thorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs W. G. Brown (Address) 540 Robert St

15 Filed MAY 3-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5 1923 to May 1 1923, that I last saw h alive on April 30 1923, and that death occurred, on the date stated above, at 6.45 Pm.

The CAUSE OF DEATH* was as follows:

Cause of the return

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) apoplexy (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jno Krauter M. D.

. 19 (Address) 2008 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Md Shadyside. Md 10 Kim DATE OF BURIAL 5-4 1923

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

IMPORTANT. See instructions on back of certificates.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D75436

CERTIFICATE OF DEATH

74-001 D75436

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 427 E Lanvale St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann E Pendergast

(Residence in Baltimore: No. 427 E Lanvale St.; 76 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6-DATE OF BIRTH Nov. (Month) ... (Day) 1847 (Year)

7-AGE 51 yrs. ... mos. ... ds. — If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE (State or country): Ireland

PARENTS

10-NAME OF FATHER: Michael Murphy

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Hughes

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Pendergast

(Address) 427 E Lanvale St

15- FILED MAY 3 - 1923 ROBERT R. KRAUTER, Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May (Month) 1 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to, May 1 1923, that I saw her alive on April 30 1923, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage causing Paralysis of left side at first, then Complete Coma. (Duration) ... yrs ... mos. 10 ds.

Contributory (SECONDARY) ... (Duration) ... yrs. ... mos. ... ds.

(Signed), E. J. Bouchelle M. D.

May 1 1923. [Address] 2104 St. Paul St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: May 5th 1923

20-UNDERTAKER: E. A. Friedlich — ADDRESS: 501 E 22 St

(1) Duplicate for Undertaker

Exact statement of OCCUPA- ... of certificate. ... See instructions on back of certificate. ... very important.

Spec.—1-10-21—M&T—1500 Blks.

D75437 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125½ Ashland Ave ST., 13 WARD)

2-FULL NAME John Frederick Warnemen

(a) RESIDENCE No. 125½ Ashland Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE) Mary E Warnemen

6 DATE OF BIRTH (month, day, and year) 12-6-1859.

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or ...min.
	63	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thomas Warnemen

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Harold Warnemen

(Address) 125½ Ashland Ave.

15 MAY 3-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1922, to May 1, 1923, that I last saw him alive on April 2, 1923, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis Mitral Regurgitation

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Physical Exam

(Signed) Frank H. Machin, M. D.

, 19 (Address) 4032 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Cemetery	May 4, 1923
20 UNDERTAKER	ADDRESS
Wm E Brooks	Sparks Md

NOTE—It is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75438

CERTIFICATE OF DEATH.

129 D75438

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 123 N 21 (St.) 17 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Taylor

(a) RESIDENCE. No. 123 N 21 St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Taylor

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 46; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: George Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Kate Taylor 123 N 21st

15 Filed MAY 3-1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 27, 1923, to May 1, 1923, that I last saw h-- alive on May 1, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

Duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Chemical Exam

(Signed) R. Garland Schmelle M. D.

(Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetry

DATE OF BURIAL: May 4 19

20 UNDERTAKER: M. Rea Elliott

ADDRESS: Walbrook

Fill in all items if possible. Typewriting or printing necessary. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-0-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75439

D75439

11-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1079 McCulloh St. WARD 11)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel James Waters

(a) RESIDENCE NO. 1079 McCulloh St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Waters

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work waiter

(b) General nature of Industry, business, or establishment in which employed (or employer) Public

(c) Name of employer St Stanley Hotel Cathedral & Mt.

9 BIRTHPLACE (city or town) (State or country) Unknown Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Rockenbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Luther Hunter (Address) 1079 McCulloh St

15 Filed MAY 3 - 1923 ROBERT N. KRAUTH, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30th 1923 to April 30th 1923, that I last saw him alive on April 30 1923, and that death occurred, on the date stated above, at 1 AM m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos. 1/4 ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 630 Vine

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) H. Lee Ellis, M. D.

(Address) 924 Mass. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 4 1923
20 UNDERTAKER	ADDRESS
Mrs R. C. Elliott	1225 Eutaw

Important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso i

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Influenza

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75440

CERTIFICATE OF DEATH.

159-003

D75440

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Scott ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Commarato

(a) RESIDENCE NO. 508 Scott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) may-1-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Commarato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mythle Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry Commarato
(Address) 508 Scott St

15 MAY 3-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923. to May 2, 1923.

that I last saw h[illegible] alive on May 2, 1923.

and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Obvious

(Signed) Reginald D. Klaus M. D.

May 3, 1923 (Address) 1 Oakland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westorm

DATE OF BURIAL May 3 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Lexington St

Write very important. See instructions on back of certificates. Exact statement of OCCUPATION is properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital Malformation

Spec. 1-10-21 M&T 1500 Blks.

D75441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D75441

1-PLACE OF DEATH St V. Infirmary.

CITY OF BALTIMORE: (No. 1401 Division St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Barrington

(a) RESIDENCE No. 1849 Hoffe Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 - 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
May 29th 1922		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Barrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago

12 MAIDEN NAME OF MOTHER Marie Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter Barrington

(Address) 5th Franklin St

15 Filed MAY 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1923, to May 2, 1923, that I last saw him alive on May 2, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. L. Goodbarn, M. D.

, 19 (Address) 2735 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL May 4 1923

20 UNDERTAKER W. R. Cook — ADDRESS 502 N. 41th Ave

Special Notice—Property classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D75442 HEALTH DEPARTMENT—CITY OF BALTIMORE D75442

CERTIFICATE OF DEATH.

5 129

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mulvina Jenkins

(a) Residence No. 32 Temple St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1906

7-AGE, 17 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.
10-NAME OF FATHER, Wm. H. Jenkins
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia
12-MAIDEN NAME OF MOTHER, Mary E. Watts
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Municipal Hospital Record
(Address) UNIVERSITY OF MARYLAND.

15- Filed ..... 192.... ROSEAL H. KRAUTH, Registrar.
MAY 3-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 29, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 23, 19 23 to April 29, 19 23
that I last saw her alive on April 29, 19 23,
and that death occurred, on the date stated above, at 7:45 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Uraemia
(Duration) ..... yrs. ..... mos. 10 ds.

18-Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. A. McKay M. D
4-30-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ... 19....
20-UNDERTAKER. Commissioner Health.	ADDRESS. MAY 3-1923

Wm. F. WOODALL

Attachment of OCCUPATION is very important. See back of certificates.

Spec– 12-23-21–E.B.R.S.—400 Bks.

D75443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., No Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Williams

(a) Residence No. Unknown St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year)

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS

10-NAME OF FATHER. ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Sarah Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Record

(Address) UNIVERSITY OF MARYLAND

15- Filed MAY 3 1923 192 ROBERT V. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 29 19 23 to May 1 19 23

that I last saw him alive on April 30 19 23

and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. Mackay M. D

5-1- , 19 23 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. ..... 19..

20-UNDERTAKER. ADDRESS

Commissioner Health, MAY 3-1923

For Wm. E. WOODALL

See instructions on back of certificates. Statement of OCCUPATION is very important.

D75444

Spec—12-23-21—E.B.K.S.—400 Bks.

D75444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3618 Greenmount ave 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Hasenkamp

(a) Residence No. 3618 Greenmount St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 18-1877

7-AGE, 45 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS:

10-NAME OF FATHER, Anton Hasenkamp

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Caroline Boecker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Alphonse Hasenkamp

(Address) 3818 Greenmount

15- MAY 3-1923 ROBERT R. KRAUTER, Registrar.
Filed 19.. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 1st 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 19.22 to May 1 19.23

that I last saw h.m alive on May 1 19.23

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) asthenia,

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? observation ck

(Signed) Josephine Schuler M. D.

, 19 (Address) 15 E Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral | DATE OF BURIAL, May 4 19.23

20-UNDERTAKER. F. C. Krause & Son | ADDRESS 70 W. Monument

IMPORTANCE OF OCCUPATION is very important. See back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16335R.

D75445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75445

CERTIFICATE OF DEATH. X162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9 WARD)

2-FULL NAME John N. Murphy.

(a) RESIDENCE No. Perryman, Maryland ST., ... WARD Perrymans Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Nick Murphy.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Milobred Lee.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) Woods.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to May 2 1923, that I last saw him alive on May 2 1923, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Intercranial hemorrhage

(duration) yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 5-2-23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation.

(Signed) A. A. Mecel, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Pylesville Md	May 3 1923
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E North.

FAILURE to have DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Blood clot on Brain

D75446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Pier 6 - Fort Clinton St., 3 Ward) Registered No. C. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Williams

(Residence in Baltimore: No. 310 So. Bethel St.; 40 yrs., ...mos., ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: About 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Scow Capt
(b) General nature of industry, business, or establishment in which employed (or employer): 1886

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Alex Williams

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Hattie Barnes

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS GIVEN TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Williams

(Address) 1336 McElderry St

15- 1923 Robert F. Harrison, (10) Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2nd (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... Accidental ... on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. H. Bond Horton M. D. (Coroner.)

May 2nd 1923. (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal. Accidental Drowning

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Asbury — DATE OF BURIAL: May 5 1923

20-UNDERTAKER: John W. Henderson — ADDRESS 1502 Fremont Ave

See instructions on back of certificate. Exact statement of OCCUPATION is necessary. Unless the cause of death can be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

D75447 HEALTH DEPARTMENT—CITY OF BALTIMORE D75447

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4003 Groveland ave. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Geis

(a) RESIDENCE No. 4003 Groveland ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Geis

6 DATE OF BIRTH (month, day, and year): June 29 1848

7 AGE: Years 74 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Fireman

(b) General nature of Industry, business, or establishment in which employed (or employer): Bethlehem Steel Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Andrew Geis

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Mary Braem

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant (Address): Mrs. Geis 4003 Groveland ave.

15 Filed .19 Registrar

Robert P. Harris.,

-1923 Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-2 1923

17

I HEREBY CERTIFY, That I attended deceased from 4-15 .19 23. to 5-2 .19 23

that I last saw h alive on 5-1 .19 23

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

CONTRIBUTORY (Secondary) Hemiplegia (duration) yrs. mos. ds. Senile Dementia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm A Fellpeel, M. D.

5/3. 1923 (Address) 7856 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount DATE OF BURIAL 5/5/1923

20 UNDERTAKER: J. J. Moran ADDRESS 3000 E. Baltimore

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplexy

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75448

CERTIFICATE OF DEATH.

D75448

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3705 Old York Road ST., 9 WARD)

2-FULL NAME Charles Aitken Lloyd

(a) RESIDENCE NO. 3705 Old York Road ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Clements

6 DATE OF BIRTH (month, day, and year) April 3, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale - Meats

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Horatio Lloyd

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Edel

13 BIRTHPLACE OF MOTHER (city or town) Phila.
(State or country) Pa.

14 Informant Charles H. Lloyd
(Address) 3705 Old York Road

15 1923 Robert P. Harrison, ... 19 .....
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 at 1923

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1923, to May 1st, 1923.

that I last saw him alive on May 1st, 1923.

and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) one yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. Deaver, M. D.

5-2, 1923 (Address) 5 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Presbyterian Cemetery-Govans — DATE OF BURIAL: 5/4 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

IMPORTANT: See instructions on back of certificates. Exact statement of OCCUPATION is very important. Every blank must be properly classified. Unknown should be avoided. Should state

Spec. 12-23-21 - F.B.F.S. - 400 Pds.

D75449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75449

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Maley

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1839

7-AGE. 83 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Lawford Maley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 12 19 23 to May 2 19 23

that I last saw her alive on May 2 19 23

and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Mc[illegible] M. D

5-3-. 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore County

DATE OF BURIAL. May 4 1923

20-UNDERTAKER. Wm Cook

ADDRESS 502 E Fort Ave

See back of certificates.

Importance of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Blks.

(Zitnik)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75450

CERTIFICATE OF DEATH.

D75450

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Calvert St ST.: 7 WARD)

2-FULL NAME Marie Zitnik

(a) RESIDENCE. No. 1621 Calvert St ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vaclav Zitnik

6 DATE OF BIRTH (month, day, and year): Nov 1 1846

7 AGE: Years 76; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Vaclav Zitnik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

11 Informant (Address): Mrs. Ella Zitnik 1621 Calvert St

13 Filed 5-7-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1923

17

I HEREBY CERTIFY, That I attended deceased from 4-29 1923 to May 2 1923 that I last saw h[illegible] alive on May 2 1923 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

5-7, 1923 (Address) 90 on Mail Order

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: K. of P. Keener — DATE OF BURIAL: May 5 1923

20 UNDERTAKER: Jack Loudon — ADDRESS: 906 Ashland

Note.—This certificate may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75451

D75451

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N Stricker ST. St. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis L. Tolson

(a) RESIDENCE. NO. 1037 N Stricker st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Late John A Tolson

6 DATE OF BIRTH (month, day, and year) April 4th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elija Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Oakley Tolson

(Address) 2407 W Lanvale st

15 Filed MAY 3 1923, 19 Robert L. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 3, 1923, that I last saw h[illegible] alive on May 3, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Sclerosis & Senility

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General Exam.

(Signed) J. Howard Tolson, M. D.

19 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: May 5th 1923

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

THIS is very important. See instructions on back of certificates. Exact statement OCCUPA-

Spec—12-23-21—E.B.P.S.—400 Blks.

D75452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D75452

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospt St. W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Thornhill.

(a) Residence No. 3 W. 24th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) —

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 23 1858

7-AGE. 64 yrs. 10 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, John Thornhill

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER Catherine Rein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Jersey

14- (Informant) Mercy Hospt

(Address) Mercy Hospt

15- Filed May 1 1923 Robert P. Garrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 1 1923

17- I HEREBY CERTIFY, That I attended deceased from April 29 1923 to May 1 1923

that I last saw h~~e~~r alive on May 1 1923

and that death occurred, on the date stated above, at 6:50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

7
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Samuel J Cavagnaro M. D.

5/1/1923 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount — DATE OF BURIAL. 5/4/23

20-UNDERTAKER. Jos A Farley ADDRESS Fulton Ave & Fayette

Duplicate Certificate of DEATH is very important. See Rules for Certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75453

CERTIFICATE OF DEATH.

D75453

1-PLACE OF DEATH

REGISTERED No. C 31

CITY OF BALTIMORE: (No. 3000 Baker ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel F Smith

(Residence in Baltimore: No. 3000 Baker St.; 28 yrs., 11 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 1, 1894
(Month) (Day) (Year)

7-AGE, 28 yrs. 11 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Edward Dunnock

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER Carrie Meeking

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George A. Smith

(Address) 3000 Baker St.

15-

Filed Robert P. Harrison, 1923

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from DEC 1922, to May 2 1923, that I saw her alive on May 1 1923 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) W S Lloyd M. D.

May 3, 1923 (Address) 2232 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, May 5, 1923

20-UNDERTAKER Elmer N. Conklin,

ADDRESS 924 E. Eager St.

Spec—12-23-21—E.B.R.S.—400 Pks.

D75454

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75454

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 522 N Rose St., 7 Ward) Registered No. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Granlund

(a) Residence No. 522 N. Rose St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Bridget Granlund

6-DATE OF BIRTH (month, day and year) April 4th 1862

7-AGE. 61 yrs. 9 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Boarding

(b) General nature of industry, business, or establishment in which employed (or employer) House Master

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Sweden

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Bridget Granlund

(Address) 522 N Rose St

15- Filed 192 Registrar.

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3- 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1922 to May 3, 1923

that I last saw h[illegible] alive on May 3, 1923

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pulmonary Tuberculosis

(Duration) 7 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1622 Thames St

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

, 19 (Address) 332 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Oak Lawn — DATE OF BURIAL, May 6, 1923

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2060 Eastern Ave

Spec.—1-10-21—M&T—1500 Blks.

D75455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75455

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 E. Hoffman St., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Venanzi

(a) RESIDENCE NO. 1600 E. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 19-1922

7 AGE 1 Years 3 Months 13 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Luigi Venanzi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Giulia Di Carlantonio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Luigi Venanzi
(Address) 1600 E. Hoffman st.

15 Filed 1923 Robert P. Garrison, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 2, 1923, that I last saw h-- alive on May 2, 1923, and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. L. Reitzel M. D.

May 3 1923 (Address) 1038 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent's Cem. | DATE OF BURIAL 5/4/23 19

20 UNDERTAKER Geo. L. Pultz 1733 | ADDRESS Harford Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

163266, D75456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D75456

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Collins (East Brooklyn, Maryland.)

(a) RESIDENCE No. 67 - 3rd St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Collins (Mother)

6 DATE OF BIRTH (month, day, and year) Oct. 22, 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	5.	6.	11.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A child.

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Collins.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Burke.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSP.

(Address)

15 MAY 4-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1923, to May 3, 1923, that I last saw him alive on May 2, 1923, and that death occurred, on the date stated above, at 12 00 A. m.

The CAUSE OF DEATH* was as follows:

Brain tumor (glioma in cerebellar pontine angle)

(duration) yrs. 4 mos 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of May 2, '23

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H. H. Weech, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Girdeltree Worcester Co. Md. DATE OF BURIAL May 4 1923

20 UNDERTAKER H. Sander & Sons ADDRESS 1210 Fleet St

IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75457

CERTIFICATE OF DEATH.

161-001

D75457

1-PLACE OF DEATH: Merrill park.

CITY OF BALTIMORE: (No. 2237 Georgetown Road ST. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna Marie McCauley

(a) RESIDENCE. NO. 2237 Georgetown Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Infant

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): Apr. 25, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
hr	—	—	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant. none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Joseph McCauley.

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Goldie Rotgut. May 3

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Goldie McCauley (Address) Merrell park.

15 Filed MAY 4 1923 . 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1923, to May 3, 1923, that I last saw her alive on May 7, 1923, and that death occurred, on the date stated above, at 6.45a. m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth. (8 mo)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Raymond Glenn, M. D.

May 3, 1923 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	May 4th 1923
20 UNDERTAKER	ADDRESS
A. Jones	111 S. Gilmor

This is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified.

D75458

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-61

D75458

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

2-FULL NAME Frederick Zuck

(Residence in Baltimore: No. ~~XXX~~ 240 S. Bond St.; yrs. ~~four~~ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	White	~~Married~~ Single

6-DATE OF BIRTH. Sept. 4/1893 1.....
(Month) (Day) (Year)

7-AGE. 29 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or. ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mill hand
(b) General nature of industry, business, or establishment in which employed (or employer): Rolling Mill

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). H H

12-MAIDEN NAME OF MOTHER. H H

13-BIRTHPLACE OF MOTHER. (State or Country). H H

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address).....

15. Filed MAY 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 2/23 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. H. Potter M. D.
(Coroner.)

5/2/23 192.... (Address) 508 E. North Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Friendship DATE OF BURIAL. May 4 1923

20-UNDERTAKER. Jacob Lewis ADDRESS 1439 E. Baltimore

Spec.—1-10-21—M&T—1500 Blks.

D75459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D75459

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 N. Washington ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary O. Wheeler

(a) RESIDENCE NO. 718 N Washington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bernhardt

6 DATE OF BIRTH (month, day, and year) May 10-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11	23	

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work Gen Capter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm A Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lulla McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Elizabeth Wheeler
(Address) 718 N Washington

15 FILED MAY 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 2, 1923, that I last saw h[illegible] alive on May 2, 1923, and that death occurred, on the date stated above, at 8:10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D. McNaughton, M. D.

(Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	May 3 1923
20 UNDERTAKER John Deerich	ADDRESS 2008 Pleasant

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ... may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75460

CERTIFICATE OF DEATH.

D75460

Registered No. 9129

1-PLACE OF DEATH

City of BALTIMORE: (No.) 957 Gorsuch St., (9) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas C Todd

(a) Residence No. 957 Gorsuch Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Anna R Todd

6-DATE OF BIRTH (month, day and year): Aug 25 1838

7-AGE: 84 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Stephen Todd

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Elizabeth [illegible]

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): Helen Shipman Son

(Address): 957 Gorsuch Ave

15- Filed MAY 4 1928 19?

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 3 1928

17- I HEREBY CERTIFY, That I attended deceased from about 1 Jan, 19.., to May 3, 1928, that I last saw him alive on May 2, 1928, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H G Prentiss, M. D.

, 19 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	May 5 1928
20-UNDERTAKER.	ADDRESS
John A Mitchell	1201 W Fayette

Spec. 12-23-21—E.M.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ D75461

D75461

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2602-Garrison-Av. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... LUTHER EICKELBERG MARTIN

(a) Residence No... 2602-Garrison-Av. St., 15 Ward... (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 59 yrs. 8 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of Verna Martin

6-DATE OF BIRTH (month, day and year) Aug-14-1863

7-AGE. 59 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Advertising
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Novelties
(c) Name of employer..... (self)

9-BIRTHPLACE (city or town)..... Hagerstown
(State or Country)..... Maryland

PARENTS.
10-NAME OF FATHER, David C. Martin
11-BIRTHPLACE OF FATHER (city or town) Hagerstown
(State or Country), Maryland
12-MAIDEN NAME OF MOTHER, Mary E. Marshall
13-BIRTHPLACE OF MOTHER (city or town) Hagerstown
(State or Country), Maryland

14- (Informant) Mrs. Verna Martin, (wife)
(Address) 2602-Garrison-Av., City.

15- Filed MAY 4-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-2-23

17- I HEREBY CERTIFY, That I attended deceased from June 1915 to 5-2 1923
that I last saw him alive on 5-2 1923
and that death occurred, on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation
Myocarditis (Duration) yrs. mos. 1/2 week

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

5/3 1923 (Signed) [illegible] M. D
(Address) 2506 Garrison Av.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hagerstown, Md.	May-5-23. 19....
20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

Attention is very important. See reverse side for Certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75462

CERTIFICATE OF DEATH.

129

D75462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 E. Eager ST. 10 WARD)

2-FULL NAME Frances Kress

(a) RESIDENCE NO. 608 E. Eager ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE of~~ John Kress

6 DATE OF BIRTH (month, day, and year) June 14 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Mr. Kuchler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mr. Joseph Kress 308 S. Calhoun St.

15 MAY 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from April 28 , 1923 , to May 3 , 1923 , that I last saw h— alive on May 3 , 19 23 , and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Clinical

What test confirmed diagnosis? Chemical & Clinical

(Signed) James McPherson, M. D.

5/4, 1923 (Address) 700 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 7 1923

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1301 E. Eager St.

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Also the exact kind of business in which deceased was employed must be stated

Spec.—1-10-21—M&T—1500 Blks.

D75463 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Levy

(a) RESIDENCE NO. 422 N. Eutaw St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ·

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Samuel Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Levy (Address) 422 N. Eutaw St

15 MAY 4-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1923, to May 3, 1923

that I last saw him alive on May 3, 1923

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency, with Pulmonary Edema

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi S. DiStefano M. D.

May 4 '23 (Address) 407 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave

DATE OF BURIAL May 4 1923

20 UNDERTAKER May Levinson

ADDRESS 1127 E Balto St

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. If not properly classified, it may be returned for correction.

Spec. 6-9-1 D75464 Bks.

(Piacentino) D75464

HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1604 N. Milton ave St.; 8 WARD)

2-FULL NAME Raymond Piacentino

(a) RESIDENCE. NO. 1604 N. Milton ave St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8 1922

7 AGE — Years 10 Months 25 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nicola Piacentino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Ines. Parmigiani

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

11 Informant Nicola Piacentino
(Address) 1604 N. Milton ave

15 Filed MAY 4 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1923, to May 2, 1923, that I last saw h[illegible] alive on May 3, 1923, and that death occurred, on the date stated above, at 12 M m.

The CAUSE OF DEATH* was as follows:

Ac Gastritis. (Enns Dis[illegible])

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Chem. Exam

(Signed) Jos Curtis Bladen, M. D.

(Address) 1453 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 5/4 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

Spec. 6-9-12—H. P. Co.—1000 Rks.

(Mildred Boone)

D75465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75465

CERTIFICATE OF DEATH.

7H-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1209 Shields Alley ST.) 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Boone

(a) RESIDENCE. No. 1209 Shields Alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housing

(b) General nature of industry, business, or establishment in which employed (or employer) — 070

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Richard Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Winkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary E. Jackson

(Address) 209 Shields alley

15 Filed MAY 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-1923

17

I HEREBY CERTIFY, That I attended deceased from April 22 - 1922, to May 1st 1923.

that I last saw h[illegible] alive on May 1st 1923

and that death occurred, on the date stated above, at 1030 a m.

The CAUSE OF DEATH* was as follows:

Hemmhage of Brain

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertrophied prostate

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Jas A Carlyn, M. D.

. 19 (Address) 1063 Hyde Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Ft Auburn Cem — DATE OF BURIAL 5/3 19 23

20 UNDERTAKER Samuel T Hemsley — ADDRESS W Baltimore

THIS IS very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPATIONS should state

D75466 HEALTH DEPARTMENT—CITY OF BALTIMORE D75466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. dat St., 11 Ward) 197 Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie allen

(Residence in Baltimore: No. 892 Tyson St St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH, April (Month) 1. (Day) 900 (Year)

7-AGE, 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), U

12-MAIDEN NAME OF MOTHER, Rob. Laws,

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Alley

(Address) 892 Tyson

15- MAY 4 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 30 (Day) 25 (Year) 192...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of abdomen
2 days
Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
May 4 1923 (Address) 1639 Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, 5/3 1923

20-UNDERTAKER, Samuel S Handy ADDRESS W Balto 28

Is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75467 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75467

CERTIFICATE OF DEATH.

15-31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 N. Mount ST.; 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grafton Biddle

(a) RESIDENCE. NO. 1420 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced (or) WIFE of Leenia Biddle

6 DATE OF BIRTH (month, day, and year) July-18-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Grant E. Biddle Sr

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie L. Bowen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs Annie L. Biddle
(Address) 1420 N. Mount

15 Filed . 19

ROBERT R. KRAUTER
Burial Permit Clerk.

MAY 4-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April May 2 1923

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1923, to May 2nd, 1923, that I last saw him alive on May 2nd, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary phthisis

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms.

(Signed) John E. S. Campbell, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	✓/✓ 1923
20 UNDERTAKER Samuel Hemsley	ADDRESS ✓ Bell

TION is very important. See instructions on back of certificates.

...that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-1021—M&T—1500 Blks.

D75468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75468

CERTIFICATE OF DEATH.

X 123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bertha Todd

(a) RESIDENCE NO. Denton ST., WARD Denton Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. A. Todd

6 DATE OF BIRTH (month, day, and year) Oct 2-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	51	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic D 57

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Denton, Md.

PARENTS

10 NAME OF FATHER Joseph Everangam

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Bertha Everangam

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hospital Records (Address)

15 Filed MAY 4 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 4 - 1923

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to May 4, 1923, that I last saw h alive on May 4, 1923, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis.

Cholelithiasis.

unknown yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? yes Date of 3-6-23. 5-3-23.

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forbes Sta. Md

DATE OF BURIAL May 4 1923

20 UNDERTAKER Wm J Tickner & Sons

ADDRESS N Y Ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75469

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75469

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Windsor + Garrison Aves.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Windsor Court Apts WARD 2)

2-FULL NAME David J. Grinsfelder

(a) RESIDENCE No. Windsor Court Apts. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of May S. Grinsfelder

6 DATE OF BIRTH (month, day, and year) May 30 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clothing 845

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Grinsfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hannah Rider

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. May Grinsfelder (Address) Windsor Court Apts

15 MAY 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1923, to May 3, 1923, that I last saw him alive on May 3, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C Wilson Bonsall, M. D.

, 19 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	5/6/ 1923
20 UNDERTAKER	ADDRESS
David Sondheim	118 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified, so that it may

Spec.—12-23-21—E.B.R.S.—400 Blks.

D75470 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75470

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 3108 Baker St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Warner

(a) Residence No. 3108 Baker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Warner

6-DATE OF BIRTH (month, day and year) Dec 4th 1845

7-AGE. 77 yrs. 6 mos. 29 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House

(b) General nature of industry, business, or establishment in which employed (or employer). Wife

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Style

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Harbert Warner

(Address) 3108 Baker st

15- MAY 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 3 1923

17- I HEREBY CERTIFY, That I attended deceased from April 3 19 23 to May 3 19 23

that I last saw her alive on May 3 19 23

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. H. A. Mayer M. D.

May 4, 1923 (Address) 2730 Hilldale Road.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park	5/7/23, 19
20-UNDERTAKER,	ADDRESS
Em. Wilson & Son	2503 Edmondson Ave

Do not write below this line. See reverse side of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75471

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75471

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lacy St. Mt. Vernon St. 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Scott

(a) RESIDENCE. No. Lacy St. Mt. Vernon St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 2 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Ernest Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lillian Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lillian Scott (Address) Mt Vernon, Md

15 Filed MAY 4 - 1923 . 19 ROBERT R. KRAUTHEIM Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/24/ 1923, to 5/21/ 1923, that I last saw him alive on 5/1/ 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J B Hartstein M. D.

5/24/ 1923 (Address) 912 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL May 19

20 UNDERTAKER Mrs Gertrude Foster

ADDRESS 406 N. Carey

IMPORTANT.—Certificates should state name of street and number in which death occurred. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Bks.

D75472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D75472

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1055 Falls Rd. St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary A Tunney

(a) Residence No..... 1055 Falls Road St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 4, 1867

7-AGE, 55 yrs. 5 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House keeping

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Wm Tunny

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah Cashin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs Sadie Tunney

(Address) 1055 Falls Rd.

15- Filed MAY 4 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 27th, 1923, to May 3rd, 1923, that I last saw h.r alive on May 3rd, 1923, and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) 4 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) 4 yrs. 4 mos. 4 ds.

18-Where was disease contracted If not at place of death? ?

Did an operation precede death? No Date of 4

Was there an autopsy? No

What test confirmed diagnosis? 4

(Signed) William G. Clotlow, M. D.

, 19 (Address) 2918 Huntingdon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St Mary's Cemetery Govans — DATE OF BURIAL, 5/5, 1923

20-UNDERTAKER, E H Conklin — ADDRESS 924 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75473

CERTIFICATE OF DEATH.

128 D75473

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Gough ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Robert Wachter.

(a) RESIDENCE NO. 3501 Gough ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada M. Wachter.

6 DATE OF BIRTH (month, day, and year) April 12th 1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
48		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman at the

(b) General nature of industry, business, or establishment in which employed (or employer) Stewart Distillery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Andrew Wachter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Katherine Fehn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ada M. Wachter (Wife)

(Address) 3501 Gough St.

15 Filed MAY 1-1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923 to May 1, 1923

that I last saw him alive on May 1, 1923

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Toxic Gastritis

(duration) X yrs. 5 mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) X yrs. 6 mos. 3 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same as above

(Signed) Jas. J. Finan, M. D.

(Address) 249 So 2d

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn, Conn	May 4 1923.
20 UNDERTAKER Lilly + Zeiler	ADDRESS 400 S. Wolfe

THION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75474

CERTIFICATE OF DEATH.

129 D75474

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 Fulton Ave St.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sarah Simpson

(Residence in Baltimore: No. Home for the Aged of the M. E. Church St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 17 (Day), 1842 (Year)

7-AGE, 80 yrs. 11 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore County Md.

PARENTS.

10-NAME OF FATHER, Robert F. Price

11-BIRTHPLACE OF FATHER (State or Country), Harford County Md.

12-MAIDEN NAME OF MOTHER Sarah Filete.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Lowndes

(Address) 400 N. Fulton Ave

15- Filed MAY 4 - 1923, 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 20 1923, to May 3 1923; that I saw h.er alive on May. 2 1923, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ~ yrs. ~ mos. ..... ds.

CONTRIBUTORY (Secondary) Paraplegia Left

with Coma (Duration) ~ yrs. 1 mos. 3 ds.

(Signed) Geo. C. Shannon M. D.

5/4, 1923 (Address) 700 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, May 5, 1923

20-UNDERTAKER George J. Smith — ADDRESS 1532 Hollins

Form 1 10 21 — M&T — 1500 Blks.

D75475 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D75475

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE (No. 1 E. Cor Eager & Dallas ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Ward

(a) RESIDENCE NO. 150 E Eager ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ward

6 DATE OF BIRTH (month, day, and year) Jan 25 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas F. Gamme

(Address) 1044 W. Baltimore

15 4-1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 2, 1923,

that I last saw h[illegible] alive on May 2, 1923,

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

a Chronic Myocarditis (duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bed Block (duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) Walter Wards, M. D.

May 3 1923 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral May	5 1923
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Fremont Ave

From is very important. See instructions on back of certificates. Exact statement of OC[illegible]

Spec.—1-10-21—M&T—1500 Bks.

D75476

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75476

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital, 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Driscoll

(a) RESIDENCE NO. 1021 Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Driscoll

6 DATE OF BIRTH (month, day, and year): Mar 25 - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horse

(b) General nature of industry, business, or establishment in which employed (or employer): Shoer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Timothy Driscoll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann O Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine Driscoll (Address) 1021 Forrest St.

15 —1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1923

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to May 3, 1923, that I last saw him alive on May 2, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1021 Forrest St

Did an operation precede death? yes Date of April 19/23

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Labolary

(Signed) James M Anderson M. D.

5/3, 1923 (Address) 704 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: May 5 1923

20 UNDERTAKER: H. C. Wiedefeld 914

ADDRESS: Fremont

Burial Permit Clerk.

HON. is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...uld state ...may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75477 D75477

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P Allerson

(a) RESIDENCE NO. 811 S. Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber assistant

(b) General nature of Industry, business, or establishment in which employed (or employer) Jos H Miller Bro

(c) Name of employer 811 S Sharp St

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Robert T. Harrison,

15 Filed ..., 19... Burial Permit Clerk. Registrar

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1923, to April 27, 1923, that I last saw him alive on April 27, 1923, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphyletic Aortitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P-S. & S

(Signed) John J. Kiegin, M. D.

19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL MAY 4 1923

20 UNDERTAKER Commissioner Health.

ADDRESS

Dr. Wm. E. WOODALL

TION is very important. See instructions on back of certificates.

D75478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Foot of Clinton St., 16 Ward) Registered No. C 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Long

(Residence in Baltimore: No. Unknown St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Unknown

6-DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7-AGE: About 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Unknown

PARENTS:

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- Robert F. Harrison, 192 Registrar.

MAY 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 30 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Kerby M. D.
Coroner.

May 2nd 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, 19

29-UNDERTAKER, Commissioner Health. ADDRESS MAY 4 - 1923

Per. Wm. H. WOODALL

HS Bone Off.

See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

D75479 HEALTH DEPARTMENT—CITY OF BALTIMORE D75479

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 S 15th ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorthea A. Perkins

(a) RESIDENCE NO. 616 S. 15th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 29-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Edward Perkins

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Bengel

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Minnie Perkins
(Address) 616 S. 15th

15 1923 Robert P. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 4, 1923, that I last saw h alive on May 4, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. Wallace Thomas, M. D.

1923 (Address) 1228 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL 5/7/ 1923

20 UNDERTAKER J. F. Moran — ADDRESS 3900 E. Baltimore St.

IMPORTANT: This certificate must be properly classified. Exact statement of OCCUPATIONS on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.75480

D.75480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 Mura ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Rabigan

(a) RESIDENCE. No. 723 Mura ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Andrew Rabigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) wife 723 Mura St.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1923, to May 3, 1923, that I last saw h[illegible] alive on May 2, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Paralysis R. side body

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F F Kirby, M. D.

(Address) 110 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	May 7 1923
20 UNDERTAKER Margaret D. Flynn	ADDRESS 1422 Light St

Important. See instructions on back of certificates. Exact statement of OCCUPA- ... properly classified.

Spec.—1-10-21—M&T—1500 Blks.

D75481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75481

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 N. Fremont ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Haugh.

(a) RESIDENCE NO. 829 N Fremont ST., ... WARD 17
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Thompson

6 DATE OF BIRTH (month, day, and year) Oct 4 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Market Man

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Solomon Haugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine Glyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs Wm E Haugh
(Address) 829 N. Fremont

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan — 1921, to May 31 1923.

that I last saw h alive on May 31 1923

and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? urine & syp

(Signed) Geo. W. Hemmeter M. D.

(Address) 3002 Garrison Blvd. 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn — DATE OF BURIAL Oct 7 1923

20 UNDERTAKER Wm Cook — ADDRESS 501 E North Ave

Note—Items must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75482

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 ✓ D75482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4501 Liberty Hts Ave 24 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Michael Hodges

(a) RESIDENCE NO. 4501 Liberty Hts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Adele Hodges

6 DATE OF BIRTH (month, day, and year): Sept 9, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: D. E. Foote & Co.

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Thomas Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Ann Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm D. Hodges

(Address): 4501 Liberty Hts Ave.

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to May 3, 1923, that I last saw him alive on May 3, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute gastritis

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Walter Lacey, M. D.

May 4, 1923 (Address) 2406 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 1923

20 UNDERTAKER: Wm J. Fichtner & Sons ADDRESS North Ave

IT IS VERY important. See instructions on back of certificates. It may be properly classified. Exact statement of CAUSE OF DEATH should

Spec.—1-10-21—M&T—1500 Bks.

D75483

16 D75483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1 D75483

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene White

(a) RESIDENCE No. 174 N. Dallas St., ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 6, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Halland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 Robert P. Harrison, . 19 ..... Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 4, 1923, that I last saw her alive on May 4, 1923 and that death occurred, on the date stated above, at 4 10 a.m.

The CAUSE OF DEATH* was as follows:

Generalized Miliary tuberculosis

? (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) ..... yrs. ..... mos 18 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) A. F. Wiesh, M. D.

. 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	May 6 1923
20 UNDERTAKER Wm R A Elliott	ADDRESS 125 Ashland Av

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

163317. D75484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D75484

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

2-FULL NAME David Eccleston.

(a) RESIDENCE NO. 2549 Oak St. City, ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. life ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a (If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24, 1921.

7 AGE — Years: 1 — Months: 8 — Days: 11 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: David Eccleston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Virginia Wyatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL

(Address): Records

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 2, 1923, that I last saw him alive on May 2, 1923 and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Generalized miliary tuberculosis

? (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) ..... yrs. ..... mos. 21 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) H. H. Mixell, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: May 5 - 1923

20 UNDERTAKER: Mrs R A Elliott — ADDRESS 1725 Ashland

934

FION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75485 ✓ D75485

CERTIFICATE OF DEATH.

44

D75485

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (NO. Caroline & Oliver St. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine J. Weber.

(a) RESIDENCE NO. 338 S. Woodyear St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip Wm. Weber

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Lillian Russell (Address) 338 S. Woodyear St.,

15 1923 Robert P. Harrison, Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 22 1923 to May 3 1923, that I last saw her alive on May 3 1923, and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. S. & Lab.

(Signed) J. V. Jezierski, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: May 7 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard St.

Spec.—1-10-21—M&T—1500 Bks. Exact statement of OCCUPATION must be properly classified. See instructions on back of certificates. This is very important.

Spec. I-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75486

CERTIFICATE OF DEATH.

38 D75486

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 422 S. Stricker ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Monthley

(a) RESIDENCE NO. University Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie L

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... mnts.
	72.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer Baltimore & Ohio R.R.Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER — Monthley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address) 422 S. Stricker St.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923.

17 I HEREBY CERTIFY, That I attended deceased from 2/14, 1923, to 5/2, 1923, that I last saw him alive on 5/2, 1923, and that death occurred, on the date stated above, at 6.03 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis
Paralysis Agitans
Senility

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? outside

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Leon Jordan, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 5 1923

20 UNDERTAKER	ADDRESS
Henry H. Witzke	1581 W Lombard

FROM is very important. See instructions on back of certificates. Exact statement of OCCUPA- ... may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75487

CERTIFICATE OF DEATH.

D75487

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1236 Union Ave. St. 13 WARD)

2-FULL NAME Mrs Sarah Enson

(a) RESIDENCE NO. 1236 Union Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William W. Enson

6 DATE OF BIRTH (month, day, and year) March 18 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co. Penn

PARENTS

10 NAME OF FATHER David Raffensberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Co Pa

12 MAIDEN NAME OF MOTHER Mary Hess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Co, Penn

14 Informant (Address) Wm W. Enson 1236 Union Ave

15 5-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1923

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to May 4, 1923, that I last saw h alive on May 4, 1923, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Cellulitis + Septicemia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis, Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1236 Union Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart, pulse + reflexes

(Signed) Herbert M. Foster, M. D.

, 19 (Address) 44 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wesley Carroll Co DATE OF BURIAL May 7 1923

20 UNDERTAKER Ehenowith & Son ADDRESS Chestnut

HOUR is very important. See instructions on back of certificates. Exact statement of OCCUPA... should be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Varicose Vein of Leg

1933

D75488 HEALTH DEPARTMENT—CITY OF BALTIMORE D75488

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. W. P. D. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Dorothy Luckart

(Residence in Baltimore: No. St. Vincents Orphan Asylum St.; yrs., mos. 6 ds. 14)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Oct. 20, 1922
(Month) (Day) (Year)

7-AGE. yrs. 6 mos. 14 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Luckart

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Margaret Cannon

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Luckart

(Address) 501 Reynolds Ave.

15- Robert P. Harrison,
Filed ..... 192 ..... Registrar.

1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Suffocation accidental

1

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

192.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem	May 5 1923
20-UNDERTAKER.	ADDRESS
Lilly and Zeiler	403 S. Wolfe St.

Fill in all items, if possible. Typewrite or print in ink. Exact statement of OCCUPATION necessary. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

D75468 D75489

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D75489

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., No (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mason

(a) RESIDENCE No. 309 S. Clinton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. Baltimore mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Mason

6 DATE OF BIRTH (month, day, and year) May 27-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Lydia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 5-1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 23d, 1923, to May 3d, 1923, that I last saw him alive on May 3rd, 1923, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

POST-OPERATIVE PNEUMONIA.

FOLLOWING GASTROTOMY.

CARCINOMA-LARYNX (duration) yrs. 6? mos - ds.

CONTRIBUTORY (Secondary) LARYNGECTOMY + MALNUTRITION.

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? PTS. HOME

Did an operation precede death? YES Date of

Was there an autopsy? YES

What test confirmed diagnosis? MICROSCOPIC.

(Signed) Stuart W. Taylor, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	May 7 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	1033 Wolfe

Burial Permit Clerk:

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- be properly classified. so that it may

Spec.—1-10-21—M&T—1500 Blks.

D75490

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75490

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2051 Bank. ST. V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Koski

(a) RESIDENCE NO. 2051 Bank. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Koski

6 DATE OF BIRTH (month, day, and year) 2/14/1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car repair Shop.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer B-O-R-R.

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Jacob. Koski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Rejdy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Helen Koski (Address) 2051 Bank

15 Filed 5 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 3, 1923

that I last saw her alive on May 2, 1923

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. Neer, M. D.

5/4/23 (Address) 408 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 5/7 1923

UNDERTAKER Wm Fallkowski

ADDRESS 168 Eastern Ave

THIS SPACE MAY BE USED IF NECESSARY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D75491

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 N. Patterson Park Ave. WARD) 7

2-FULL NAME Ida B. Rehberger

(a) RESIDENCE No. 735 N. Patterson Park Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C. Rehberger

6 DATE OF BIRTH (month, day, and year) March 16- 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. E. Fray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Charles C. Rehberger

(Address) 735 N. Patterson Park Ave

1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1923, to May 3, 1923, that I last saw h[illegible] alive on May 3, 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Abm B Lerman, M. D.

5/4, 1923 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL May 7 1923

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1739 Eager

Burial Permit Filed

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75492

CERTIFICATE OF DEATH.

1823 D75492

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Jones Falls near Druid St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Robert Butler

(Residence in Baltimore: No. 219 No. Durham St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)

7-AGE. 47 about yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS:

10-NAME OF FATHER. Thos Butler

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Susan Smith

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS DUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Butler

(Address) 219 No. Durham St

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3 (Month) (Day) 192..3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry.) found that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental

Drowning

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Dr. E. Horton M. D.

(Coroner)

May 5 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Asbury

DATE OF BURIAL. May 7 1923

20-UNDERTAKER. John W Henderson

ADDRESS 1302 E Monument

Instructions: Fill in all items, if possible. Typewrite or print plainly in black ink. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D75493

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75493

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 660 W Mulberry st, St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nattie L Davis

(Residence in Baltimore: No. 660 W Mulberry st St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed or Divorced (Write the word)
Male	Col.	Mard

6-DATE OF BIRTH. ..... (Month) ..... (Day) ..... (Year)

bout Know 82

7-AGE. 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. Dennis Davis

11-BIRTHPLACE OF FATHER, (State or Country). N. C.

12-MAIDEN NAME OF MOTHER. Mary Peil

13-BIRTHPLACE OF MOTHER, (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. N. Davis

(Address) Lewisburg Pa

15-

Filed ..... 1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the heart

(Duration) bout know yrs. mos. ds.

CONTRIBUTORY (Secondary) bout know

(Duration) yrs. mos. ds.

(Signed) H. N. Gorsuch M. D.
(Coroner)

5-5 1923 (Address) 117 N Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lutheran DATE OF BURIAL, 5/5 1923

20-UNDERTAKER, Samuel Hemsley ADDRESS 1 Biddle St

See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D75494

CERTIFICATE OF DEATH.

84 D75494

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2735 Bernard St. ST. 12 WARD)

2-FULL NAME Thomas Chester Holmes

(a) RESIDENCE NO. 2735 Bernard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year): February 3rd 1923

7 AGE: Years — Months 3 — Days 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Joseph H. Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Julian Poston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Joseph H. Holmes 2735 Bernard St

15 Filed 1923 — Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 21st 1923, to May 4th 1923.

That I last saw h alive on May 4th 1923

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Convulsions due to Cerebral Pressure

8/ Coroner Inquest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral pressure

(duration) y 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Lung Troyd 116 E. M. D.

1923 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery.

DATE OF BURIAL: 5/5 1923.

20 UNDERTAKER: Walter Davis

ADDRESS 3307 Paine St

THION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified. ... state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Due to accident
before birth.

D75495

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75495

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Broening

(Residence in Baltimore: No. 25 S. 11th St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Widow

6-DATE OF BIRTH. April 13/1869 (Month) (Day) (Year)

7-AGE.			If LESS than 1 day,
54 yrs.	20 mos.	ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Adam Schissler

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Kate ---------

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Schlissler

(Address) 25 S 11th St.

15-

Filed 19 Robert P. Harrison, Registrar.

1923 Burial Permit Given.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Y. Cain M. D. (Coroner)

5/4/23 (Address) 508 E. North Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Carmel	May 7th 1923
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

Important. See instructions on back of certificate. Exact statement of OCCUPATION

D75496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75496

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1037 Hartford Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME. Rose Kaufman

(Residence in Baltimore: No. 1037 Hartford Ave St. 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Single

6-DATE OF BIRTH. Dec. (Month) (Day) 1... (Year)

7-AGE.	If LESS than 1 day,
82 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER. Godfried Kaufman

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Susanna Kaufman

13-BIRTHPLACE OF MOTHER, (State or Country). German

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. C. Evans

(Address) 2113 N Calvert

15-

Filed, 192... Registrar.

1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 27th to May 4 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insufficiency (Valvular)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) History of Rheumatism for yrs

(Duration) yrs. mos. ds.

(Signed) J. S. Hoffer M. D.

(Coroner)

5/5 1923 (Address) 508 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer	May 5, 1923

20-UNDERTAKER,	ADDRESS
Wm Cook & Son	E. Fayette

See instructions on back of certificate. Exact statement of OCCUPATION

Spec—12-23-21—E.B.R.S.—400 Blks.

D75497

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D75497

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Davis

(a) Residence No. 1525 W. Fayette St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 2 1831

7-AGE. 91 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Wm. T. Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Harriet Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 5-1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 4, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 12, 1923, to May 4, 1923, that I last saw her alive on May 3, 1923, and that death occurred, on the date stated above, at 11:25 A. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McKay M. D

5-5-. 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park DATE OF BURIAL. May 7, 1923

20-UNDERTAKER. Wm Cook ADDRESS 501 E North ave

OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75498

CERTIFICATE OF DEATH.

D75498

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 377 St Helena Ave St. 20a WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Richard

(a) RESIDENCE. No. 377 St Helena Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Allen E. Richard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mabel Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Allen E. Richard (Address) 377 St Helena Ave

15 Filed Robert F. Harrison, Registrar

1973 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1923

17

I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 4, 1923, that I last saw him alive on May 4, 1923, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) measles

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. D. Reese, M. D.

5/7, 1923 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	May 6, 1923

20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Ft. Ave

This is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75499

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 N. Broadway ST.: 8th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Amelia Sophia Davis

(a) RESIDENCE. NO. 1821 N. Broadway ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. Approximate mos. ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Late Joseph E. Davis

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day hrs. or X min.
67 Appxy	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Joshua Oram

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Elizabeth Grove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) J. W. Davis 1821 N. Broadway.

15 Filed MAY 5 1923 Robert F. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 30 1923, to May 3, 1923, that I last saw h~~er~~ alive on May 2nd, 1923, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Peri-portal Carcinoma = Lipomatous Carcinoma (Mesenteric) from a primary lesion of Scirrhous = Solanoid Carcinoma of Uterus (duration) not determined yrs. mos. ds.

CONTRIBUTORY (Secondary) Syncope from Jaundice toxia (duration) X yrs. X mos. 7 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of ✓

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy + Pathological

(Signed) P. Reilach, M. D.

5/3, 1923 (Address) 1124 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 5 1923
20 UNDERTAKER	ADDRESS
Geo. F. Ruth.	1735 Harford Ave.

Note.—This is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—MAT—1500 Blks.

D75500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75500

CERTIFICATE OF DEATH.

159-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1401 (St.) Clifton Ave (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hatt.

(a) RESIDENCE NO. 1401 ST. Clifton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May. 2. 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Gordon M Hatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore W. Va.

12 MAIDEN NAME OF MOTHER Helen Pauhe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Gordon M. Hatt 1401 Clifton Ave

15 Filed 1923, 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1923

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1923, to May 2, 1923, that I last saw he alive on May 2, 1923, and that death occurred, on the date stated above, at 6 23 A. m.

The CAUSE OF DEATH* was as follows:

asphyxia Fluvida

(duration) yrs. moa da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Krumbock M. D.

5-2, 1923 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	May 3 1923
20 UNDERTAKER	ADDRESS
Wm Cooke	502 E North Ave

IMPORTANT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75501

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75501

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division St ST., 16 WARD)

2-FULL NAME. Catherine Adeline Dawson

(a) RESIDENCE NO. 2718 Winchester St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16 1923

7 AGE	Years	~~F~~Months	~~Da~~ys	If LESS than 1 day, hrs. or min.
		1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Vincent E. Dawson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Michigan

12 MAIDEN NAME OF MOTHER Ethel Humphries

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14 Informant Vincent E. Dawson
(Address) 2718 Winchester

15 Filed MAY 5 - 1923 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 5, 1923,

that I last saw h alive on May 5, 1923,

and that death occurred, on the date stated above, at 12:10 A. m.

The CAUSE OF DEATH* was as follows:

Infantile atelectasis

Congenital

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) Edwin B. Jarrell, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL. 19
Woodlawn	
20 UNDERTAKER Wm J. Tickner & Son	ADDRESS N & Pa

TION is very important. See instructions on back of certificates.

...certificate may be properly classified. Exact statement of ...

Spec. 1-10-21 M&T 1500 Blks.

D75502

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

OK Maynard Coroner Fri D.

188-00

D75502 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Weigner

(a) RESIDENCE NO. 872 N. Balto. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1868 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer) Railroad R.R.

(c) Name of employer Washington Balt. & Annapolis

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER May Dall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital records (Address)

15 Robert P. Harrison, Burial Permit Clerk. Registrar

-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2- 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to May 3, 1923, that I last saw h[illegible]alive on May 3, 1923, and that death occurred, on the date stated above, at 330P m.

The CAUSE OF DEATH[2] was as follows:

Acute Uremia

Chronic Diffuse Nephritis (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Fractured Pelvis - Rt. Side (duration) yrs. mos. 2 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) G. B. Hallen, M. D.

May 3, 1923 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlew Cemetery DATE OF BURIAL May 5, 1923

20 UNDERTAKER John J. Gowan & Bro. ADDRESS

Tel. J. J. Gowan 901 Holliday St.

TION is very important. See instructions on back of certificates.

Form — 1-10-21 — M&T — 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75503 — CERTIFICATE OF DEATH. — D75503

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1516 McCulloh ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Wilson

(a) RESIDENCE NO. 1516 McCulloh ST., 14 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Britta Wilson

6 DATE OF BIRTH (month, day, and year) Feb 11-1892

7 AGE 31 Years 2 Months 23 Days — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Chauffeur

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosetta Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Bertha Wilson 1516 McCulloh

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 3, 1923, that I last saw h[illegible] alive on May 3, 1923, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Douglas, M. D.

May 3, 1923 (Address) 1432 D. Hill W

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-6 1923

20 UNDERTAKER George H. Holland — ADDRESS 1630 Harlem Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified. should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Goonan) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75504

CERTIFICATE OF DEATH.

D75504

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1162 Sargeant St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude A. Goonan.

(a) RESIDENCE. No. 1162 Sargeant ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced (write the word) Divorced

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Sargeant.

6 DATE OF BIRTH (month, day, and year) Oct 28-23

7 AGE Years mo | Months mo | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Surgeon.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) mo
(State or country)

PARENTS

10 NAME OF FATHER Raymond Goonan

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Emmitt

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Lillian Goonan
(Address)

Filed ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1923

17

I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 4, 1923, that I last saw her alive on May 4, 1923, and that death occurred, on the date stated above, at 2.35 p. m.

The CAUSE OF DEATH* was as follows:

Tubercular pneumonia

(duration) mo yrs. mo mos. 3 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? mo Date of mo —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Raymond A. Goonan, M. D.

May 5, 1923 Address Peakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters | DATE OF BURIAL May 5 1923

20 UNDERTAKER James Dignan Son, | ADDRESS 1000 Pace

be properly classified. Exact statement of OCCUPA-
of certificates.
N is very important. See instructions on back of cer

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75505

CERTIFICATE OF DEATH.

July 23, 1910

90 D75505

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2207 E. Oliver ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillip Schmidt

(Residence in Baltimore: No. 2207 E. Oliver St.; 59 yrs., 8 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, August (Month) 20 (Day), 1863 (Year)

7-AGE, 59 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Andreas Schmidt

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Wilhelmina Tibeck

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Robert J. Schmidt

(Address) 2207 E. Oliver st.

15-

Filed 1923 191.... Robert B. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 4th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 1910, to May 4 1923, that I saw him alive on May 3. 1923, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 36 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Sandreck M. D.

May 5, 1923. (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	May 7, 1923
20-UNDERTAKER	ADDRESS
Henry Lutz	N. Broadway

Spec.—I 10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75506

CERTIFICATE OF DEATH.

90 D75506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3106 Windsor St. 15 WARD)

2-FULL NAME Blaine C Walter

(a) RESIDENCE NO. 3106 Windsor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: John B. Walter

6 DATE OF BIRTH (month, day, and year): March 29 1855

7 AGE — Years: 68 — Months: 1 — Days: 5 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Henry Supold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Sarah A. Augustine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: John B. Walter

(Address): 3106 Windsor Ave

1923 Robert F. Garrison,

Filed ....., 19 .....

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAY 4 1923

17

I HEREBY CERTIFY, That I attended deceased from March, 1923, to May 4, 1923,

that I last saw h.. alive on May 3, 1923,

and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Mitral and Aortic Regurg

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Anasarca

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas F Bloke, M. D.

MAY 4 1923, 19 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL: Loudon Park

DATE OF BURIAL: MAY 7 1923

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE

TION is very important. See instructions on back of certificates. ...may be properly classified. Exact statement of OCCUPA-...should state

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75507

CERTIFICATE OF DEATH.

129

D75507

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Mt Royal ST. 14 WARD)

2-FULL NAME Stephen S. Medge

(a) RESIDENCE NO. 1427 Mt Royal ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed,~~ or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Laura V Medge

6 DATE OF BIRTH (month, day, and year) July 3 1848

7 AGE: 74 Years | 2 Months | 1 Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Meat Packers

(c) Name of employer Krug & Co

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Thos S Medge

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Emily Vickery

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Ethel Medge
(Address) 1427 Mt Royal Ave

15 Filed ....., 19 Robert F. Garrison, Registrar
1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to May 7, 1923.
that I last saw him alive on May 2, 1923.
and that death occurred, on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Acute Eczema & Nephritis

(duration) 1 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Incontinence of Urine (duration) ..... yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual & Laboratory

(Signed) J Rowe Price, M. D.

May 4, 1923 (Address) Elkridge Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL Greenmount — DATE OF BURIAL MAY 7 1923

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE.

IT IS very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA- ... and State

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75508

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1252 Hull ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Doucette

(a) RESIDENCE. NO. 1252 Hull ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 If Single, Married, Widowed, or Divorced (write which) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Doucette

6 DATE OF BIRTH (month, day, and year) Nov 8-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Todd Ship Bldg Co

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Annie Doucette

(Address) 1252 Hull Street

15 Filed 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5.4.23 19

17 I HEREBY CERTIFY, That I attended deceased from 4.30.23, 19..., to 5.4.23, 19..., that I last saw him alive on 5.4.23, 19..., and that death occurred, on the date stated above, at 7.54 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

5.4.23 19 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 7 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E North

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

D75509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75509

CERTIFICATE OF DEATH. X 123

1-PLACE OF DEATH Womens Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... ST. 14 WARD)

2-FULL NAME Lena Robertson.

(a) RESIDENCE NO. Westminster Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbur Robertson

6 DATE OF BIRTH (month, day, and year) Oct 6 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Carroll Co Maryland

PARENTS

10 NAME OF FATHER Henry Gabel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Eckhoff

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs. Robertson
(Address) Westminster Md

15 MAY 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to May 5-23, 1923, that I last saw h[er] alive on May 5-23, 1923, and that death occurred, on the date stated above, at 9.29 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus

25 minutes

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of April 26 1923

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings

(Signed) Howard E Rauscenbaum M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Barrett Brandenburg Cem Md.

DATE OF BURIAL May 7 1923

20 UNDERTAKER H Bankard & Son

ADDRESS Westminster

NOTE IS very important. See instructions on back of certificates. Exact statement of OCCUPATION must be properly classified. Exact statement of CAUSE OF DEATH must be made

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation - April 26, 1923
Cholecystostomy

Diagnosis -
Empyema of gall bladder
Cholelithiasis
Cholecystitis - chronic

Spec—12-23-21—E.B.R.S.—400 Bks.

Laws

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75510

CERTIFICATE OF DEATH.

31

D75510

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 719 W Saratoga St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Laws

(a) Residence No. 719 W. Saratoga St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Sngl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan - 1905

7-AGE.	If LESS than 1 day,
18 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER, Moses Laws

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Va

12-MAIDEN NAME OF MOTHER, Mamie Ames

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Va

14- (Informant) John Ames

(Address) 108 Patapsco ave.

15- Filed MAY 6 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 1 1923 to May 3 1923

that I last saw her alive on May 3 1923

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia, Phthisis

(Duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Cooney M. D.

19 (Address) 753 Orange St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn Cem	5-7- 19 23
20-UNDERTAKER.	ADDRESS
Daniel Easton	916 Pa ave

Statement of OCCUPATION is very important. See Instructions for Certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

163014 Issued D75511

CERTIFICATE OF DEATH.

24 D75511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3 WARD)

2-FULL NAME Meyer Weiss

(a) RESIDENCE NO. 10 S. Hugh St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	9.	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Michael Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Isaacson

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 JOHNS HOPKINS HOSPITAL Informant

(Address) Records.

15 MAY 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to May 5, 1923, that I last saw him alive on May 5, 1923 and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) 0 yrs. 0 mos. 22 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of Cranial trephine April 30, 23

Was there an autopsy? None.

What test confirmed diagnosis? Culture of cerebrospinal fluid

(Signed) William H. Welker, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sylvan Dorcheste	May 6 1923
20 UNDERTAKER	ADDRESS
Jos. T. Lewis	1639 E. Balto

IMPORTANT. PHYSICIANS should state what may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75512

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 29 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie A. Neuburger

(a) RESIDENCE NO. 4. Baltimore Cty ST., ... WARD E

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1/21/1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edward M Neuburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary A Cockhaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL.

(Address) Baltimore

15 MAY 6 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/23 19

17 I HEREBY CERTIFY, That I attended deceased from 3/29/23, 19..., to 5/4/23, 19, that I last saw h alive on 5/4/23, 19, and that death occurred, on the date stated above, at 3.20 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Not known (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Chas. W. Cunningham M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 7 1923
20 UNDERTAKER	ADDRESS
William G. Schaffer	1816 Monument

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified. so that it

Spec.—6-9-19—H. P. Co.—1000 Blks.

Andoniades

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75513 D75513

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 Park ave- ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Andoniades.

(a) RESIDENCE. NO. 201 Park ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Andoniades

6 DATE OF BIRTH (month, day, and year) Sept 5- 93

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Sarator Andoniades

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Sarator

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Mrs Clara Andoniades
(Address) 201 W Saratoga St

15 Filed MAY 6 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to May 5, 1923, that I last saw him alive on May 5, 1923, and that death occurred, on the date stated above at 9.1 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

, 19 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 7 1923
20 UNDERTAKER	ADDRESS
H W Routson	230 N Greene

Instructions on back of certificate. Exact statement of OCCUPA-

Spec. D75514

HEALTH DEPARTMENT—CITY OF BALTIMORE

164 D75514

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 5824 York Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Hostetter Barr

(Residence in Baltimore: No. 5824 York Road St.; 79 yrs. 8 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, August 17, 1843
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
79 yrs. 8 mos. 19 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER, Amos Barr

11-BIRTHPLACE OF FATHER (State or Country). Lancaster Co. Pa

12-MAIDEN NAME OF MOTHER Martha Smith

13-BIRTHPLACE OF MOTHER (State or Country). Lancaster Co. Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Schull
(Address) 5824 York Road Baltimore

15-
MAY 6 1923 191... ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to May 5 1923, that I saw him alive on May 5 1923, and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

Senility - Inanition

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Jno. H. Hoskins M. D.

May 6 1923 (Address) 5535 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Springfield Ohio	May 8, 1923.
20-UNDERTAKER W M Rowlson	ADDRESS 230 N Eutaw

Please write plainly. Be sure to fill in every item. Space for each item is very limited. Abbreviations of OCCUPATION is very objectionable. Please do not write in margins of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75515
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

4 135 D75515

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1038 N. Broadway St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Pettaluta

(Residence in Baltimore: No. 1038 N. Broadway St.; 50 yrs., ... mos. ..... ds.)

10 6 20

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Nov. (Month) ..... (Day), 1873 (Year)

7-AGE, 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Anthony Pettaluta

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Celestina Pettaluta

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Pettaluta

(Address) 1038 N. Broadway

15- Filed MAY 6 - 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 5 1923, to May 5 1923, that I saw h alive on May 5 1923, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia (Nephritis)

..... (Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Hypertrophy

Carcinoma ..... (Duration) 1 yrs. .....mos. .....ds.

(Signed) Frank C. Marino M. D.

May 5, 1923. (Address) 1300 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? Home.

Former or usual residence Uebridge - Ind.

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, May 8, 1923

20-UNDERTAKER Chas. D. Evans & Son ADDRESS 118 W. Mt Royal Ave

Please write plainly. Any statement of OCCUPATION is very important. Physician or undertaker will please fill out this certificate.

Spec.—1-10-21—M&T—1500 Blks.

D75516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D75516

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Harlem ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Streb

(a) RESIDENCE NO. 725 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Streb

6 DATE OF BIRTH (month, day, and year) Nov 30 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman Von Hagel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Wessendaf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Murphey

(Address) 725 Harlem ave

15 Filed MAY 6 - 1923 . 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4- 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 , 1921 . to May 4- , 1923.

that I last saw her alive on May 2d , 1923

and that death occurred, on the date stated above, at 5-05 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Howard Heyneman M. D.

(Address) 3002 Garrison ave 4-5, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loorsine Cemetery

DATE OF BURIAL 5/7 1923

20 UNDERTAKER Chas P. Ewell Sons

ADDRESS 11 & 13 W Mt Royal ave

IMPORTANT: Physicians should state that it may be properly classified. Exact statement of OCCUPATIONS on back of certificates.

75-577

Spec.—1-10-21—M&T—1500 Blks.

Vaill

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75517

CERTIFICATE OF DEATH.

X 43

D75517

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital WARD)

2-FULL NAME Miss Julia C. Vaill

(a) RESIDENCE NO. 48 Exchange St. Portland Maine

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Captain E. E. Vaill

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Conn

12 MAIDEN NAME OF MOTHER Charlotte Sturdivant

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Portland Maine

14 Informant Frederick S. Vaill
(Address) Portland Maine

15 MAY 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1922, to May 6th, 1923, that I last saw h[illegible] alive on May 6th, 1923, and that death occurred, on the date stated above, at 12 25 m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Tonsils

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Abdominal Metastases

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Guy A. Cromwell M. D.

5/6, 1923 (Address) 148 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portland Maine

DATE OF BURIAL 5/7 1923.

20 UNDERTAKER James A Jones

ADDRESS 12-N Eutaw St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Mks.

D75518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

127 D75518

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Munder.

(a) RESIDENCE NO. Park. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna Munder

6 DATE OF BIRTH (month, day, and year) Aug 1 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Saloon Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Munder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Anna Munder 4536 Harford Road

15 MAY 7-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/23

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923 to May 4, 1923.

that I last saw h[illegible] alive on May 4, 1923,

and that death occurred, on the date stated above, at 2 15 m.

The CAUSE OF DEATH* was as follows: -p

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhages Pernicious

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 26/23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J W Feussner M. D.

(Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem DATE OF BURIAL May 7 1923

20 UNDERTAKER Mr & Mrs J.W. Teufel & Son ADDRESS 801 W. Fayette

TION is very important See instructions on back of certificates.

at it may be properly classified. Exact statement of OCCUPA-

plain terms, so that it m

Spec. 1 10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75519

CERTIFICATE OF DEATH.

100 001

D75519

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 956 Harford ave ST., 10 WARD)

2-FULL NAME Annie Darone

(a) RESIDENCE NO. 956 Harford ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

N. B.—WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Antonio Darone

6 DATE OF BIRTH (month, day, and year): 6/20/1861

7 AGE: Years 61; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Luigi Darone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Rose Demarco

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Salato Darone

(Address) 956 Harford ave

15 MAY 7-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 3, 1923

that I last saw her alive on May 3, 1923

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DiStefano M. D.

(Address) 407 N. Exeter St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May. 7 1923

20 UNDERTAKER: Geo. J. Rutt — ADDRESS: 1735 Harford Ave

Spec. 1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75520

CERTIFICATE OF DEATH.

31 D75520

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 N. Spring ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ambrose E. B. Turner

(a) RESIDENCE No. 1641 N. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Mary Turner

6 DATE OF BIRTH (month, day, and year): March 5, 1862

7 AGE: Years 60 | Months 1 | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED: Laborer

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joshua Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Riddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mary Turner

(Address): 1641 N. Spring

15 FILED MAY 7-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1923

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to May 5, 1923.

that I last saw him alive on May 5, 1923.

and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary and Laryngeal Tuberculosis

Disease must have existed for several months, but no physician was consulted.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Tuberculebacillus x ray.

(Signed) Wm. T. Watson, M. D.

May 6, 1923 (Address) 2124 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: May 8 1923

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS: 1734 Eager

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

3126 Hanford Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75521 90 D75521

D75521

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Van Zill St. ST., | WARD)

2-FULL NAME Dorothy C. Fahrman

(a) RESIDENCE NO. 703 Van Zill St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William Fahrman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Palmer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Warrner
(Address) 703 Van Zill St.

15 MAY 7-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch. , 1922 to May 6th, 1923, that I last saw h alive on May 4th 1923, and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease.

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? / Date of /

Was there an autopsy? /

What test confirmed diagnosis? /

(Signed) Robt S. Kirk, M. D.

5/7, 1923 (Address) 3126 Hanford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 9 1923
20 UNDERTAKER	ADDRESS
A. Vandiver & Sons	1710 Fleet St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75522

CERTIFICATE OF DEATH.

1/01-001 D75522

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 E. 42nd St. ; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Conway

(Residence in Baltimore: No. 500 E 42 St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. June (Month) 12 (Day), 1863 (Year)

7-AGE. 59 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): R.R.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm. A Conway

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Kate Grahme

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W H Webb

(Address) 500 E 42nd St.

15- Filed MAY 7-1923, 191.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 6th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1923, to May 6th 1923, that I saw him alive on May 6th 1923, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ....yrs. ....mos. 3 ....ds.

CONTRIBUTORY (Secondary) Weak Heart

..... (Duration) ....yrs. 1 mos. ....ds.

(Signed) Earle Duncan M. D.

May 6, 1923 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Rockhill Cem Washington Co	May 9, 1923
20-UNDERTAKER Robert Brookshaw	ADDRESS CALHOUN HOLLINS ST

Spec.—1-1021 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75523

CERTIFICATE OF DEATH.

90 D75523

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kiefer

(a) RESIDENCE No. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 MAY 7-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1922, to May 5, 1923, that I last saw him alive on May 4, 1923, and that death occurred, on the date stated above, at 4:35 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) auricular fibrillation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. A. McKay M. D.

5-5-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL May 7 1923

20 UNDERTAKER John Deering

ADDRESS 2008 [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75524 HEALTH DEPARTMENT—CITY OF BALTIMORE D75524

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1031 Rutland Ave St. 7 Ward) 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Martin Urban .....

(Residence in Baltimore: No. 1031 Rutland Ave St.; (yrs. 56) mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. AUG 16/1859 1.....
(Month) (Day) (Year)

7-AGE. 63 yrs. 8 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Urban

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hwattie Urban (wife)

(Address) 1031 Rutland Ave

15-

MAY 7 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6/23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide- Pistol shot thru right temple-passed out over left ear.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J S Wilkins M. D.
(Coroner)

5/6/23. 192.... (Address) 5pi E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Carmel	May 8, 1923
20-UNDERTAKER. John Dillon	ADDRESS 2008 Eden

D75525

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 ✓ D75525

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital, 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Charles Fisher. (C)

(Residence in Baltimore: No. 1130 Peach Alley. St.; 36 yrs., 2 mos., 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, February 6th. 1887. (Month) (Day) (Year)

7-AGE, 36 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George Fisher. (C)

11-BIRTHPLACE OF FATHER, (State or Country). Frederick Md.

12-MAIDEN NAME OF MOTHER. Rose Burton. (C)

13-BIRTHPLACE OF MOTHER, (State or Country). Cambridge, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Fisher. (C) mother.

(Address) 613 George St.

15- MAY 7 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3rd. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd. degree burns about the body.
Accidental fall in a vat of sulphuric Acid.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Shock.

(Duration)..... yrs..... mos..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

May 7th 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? Keen & Hagerty., Nat. Pk. & St. Co.

Former or usual residence. May 3rd. 1923.

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem. DATE OF BURIAL. 5/7 1923

20-UNDERTAKER. Samuel L. Newbury & Bro. ADDRESS 578

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75526

CERTIFICATE OF DEATH.

191 / D75526

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1028 Penna ave. ST.) 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alton L. Brooks.

(Residence in Baltimore: No. 1049 Myrtle ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, about (Month) (Day), 1910 (Year)

7-AGE, 13 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Ed. E. Brooks,

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Sarah E. Bayle

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. E. Brooks,

(Address) 1049 Myrtle Ave

15- MAY 7 1923 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 4, 191..

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry,) find that said deceased came to death today from the following cause on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound in Chest.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Homicide

(Duration) yrs. mos. ds.

(Signed) J. T. Hannan M. D. (Coroner.)

May 5, 191.. (Address) 28 Fremont ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodson Cemetery DATE OF BURIAL, May 7 1923

20-UNDERTAKER A. A. Co. md ADDRESS, 1027 Druid Hill ave

John H. Trader

Spec. 1-10-21 MAT 1500 Blks.

D75527

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

D75527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace White

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed MAY 7 1923 ROBERT A. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17

I HEREBY CERTIFY, That I attended deceased from February 7, 1922 to May 5, 1923, that I last saw him alive on May 4, 1923, and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. McKoy, M. D.

5-5-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL May 8 1923

20 UNDERTAKER John H. Soader — ADDRESS 1027 Hund Hill Ave

MARGIN RESERVED FOR RECORDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 D75528

REGISTERED NO.

1-PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 21 WARD)

2-FULL NAME Frank B. Wright.

(a) RESIDENCE No. 516 W. Cross St., ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced
HUSBAND of Violet Wright
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	45 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble polisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown, Md.

PARENTS

10 NAME OF FATHER William Wright.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Univ. Hosp. records
(Address)

15 MAY 7-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/2, 1923, to 5/6, 1923.

that I last saw him alive on 5/6, 1923,

and that death occurred, on the date stated above, at 6:55 a. m.

The CAUSE OF DEATH* was as follows:

Appendicitis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis, diffuse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at his home

Did an operation precede death? No Date of

Was there an autopsy? /

What test confirmed diagnosis?

(Signed) Frank D. Lyon M. D.

, 19 (Address) 1414 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	May 8 1923
20 UNDERTAKER	ADDRESS 1027
John H. Tradum	Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75529

CERTIFICATE OF DEATH.

90 D75529

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 123 E. Park Ave Raspburg St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Scherer

(Residence in Baltimore: No. 123 E. Park Ave Raspburg St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. March 26/1866 (Month) (Day) 1..... (Year)

7-AGE. 57 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Construction
(b) General nature of industry, business, or establishment in which employed (or employer) Standard Oil

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. John J. Scherer

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Theresa Steigerwald

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Scherer

(Address) 123 E. Park Ave Raspburg

15- FILED MAY 7-1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 5/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Insuffiency- Myocarditis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Rheumatism yrs ago

(Duration) ....yrs....mos....ds.

(Signed) J. E. Wallis M. D. (Coroner.)

5/6/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Parkwood Cemetery	May 8th 1923
20-UNDERTAKER.	ADDRESS
Fredk Lassahn & Sons	Fullerton

Spec.—1-10-21—MAT—1500 Blks.

D75530

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001 D75530

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 McDonough ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Dotkins

(a) RESIDENCE NO. 926 McDonough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Tahr Jackins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Mary Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Wm Jackins

(Address) 926 McDonough St

15 Filed MAY 7-1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923 to May 5, 1923.

that I last saw her alive on May 5, 1923,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jas C Robinson, M. D.

May 5, 1923 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Odd Fellows Cemetery	May 8 1923
20 UNDERTAKER	ADDRESS 631
Edward Boyer	Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Henrietta Klinger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75531

CERTIFICATE OF DEATH.

164

D75531

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 N Lexington ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Klinger

(a) RESIDENCE NO. 746 N Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Klinger

6 DATE OF BIRTH (month, day, and year) July. 18 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Home Record.

(Address)

15 Filed MAY 7-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan — 1923, to May 5 1923.

that I last saw h[illegible] alive on May 5 1923.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac asthenia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

5-6, 1923 (Address) 3002 Harrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Pauls. (Violetsville) DATE OF BURIAL: 5-7 1923

20 UNDERTAKER: Mrs. Chas. A. J. Rohde ADDRESS: 600 W Lexington

MATERIAL TO BE WRITTEN IN INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75532 ~~D75532~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75532

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Spiegel

(a) RESIDENCE NO. 1221 Kirkside Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Spiegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Tillie Thrivo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 Filed MAY 7 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to May 6th, 1923, that I last saw h alive on May 6th, 1923, and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hooton Caspario, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL May 7 1923

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe St

MARGIN RESERVED FOR REGISTRAR'S RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec. 1-10-21 M&T 1500 Blks.

D75533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D75533

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hiram Henry

(a) RESIDENCE NO. 1505 Mosher St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elliott City, Md.

PARENTS

10 NAME OF FATHER John A. Henry

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Municipal Hospital Records.

(Address)

15 Filed ....., 19 ... Robert H. KRAUTER Registrar

MAY 7 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 22, 19 23, to May 3, 19 23, that I last saw h im alive on May 3, 19 23, and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Syphilis (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. McKo M. D.

4/. 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 7 1923
20 UNDERTAKER	ADDRESS
Chas. W. Chase Son	1505 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75534

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2616 Bruce Terrace ST., 13 WARD)

2-FULL NAME Elona Bell Gray

(a) RESIDENCE No. 2616 Bruce Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 3rd 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Earnest A. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Emma A. Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Earnest A. Gray
(Address) 2616 Bruce Terrace Balto Md

15 Filed MAY 7 - 1923 Russell H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6th, 1923, to May 7th, 1923, that I last saw her alive on May 7th 1923, and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Measles

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bacteria

(Signed) Edwin C. Peikert M. D.

May 7th 1923 (Address) Cor. Pa. & Fulton Aves. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Kemmel Cem.

DATE OF BURIAL: May 8th 1923.

20 UNDERTAKER: John J. Fields

ADDRESS 1205 N. Lombard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75535 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 4 4 196 D75535

1-PLACE OF DEATH Curtis Bay Copper & Iron Works, Registered No. C.....

City of BALTIMORE: (No. Curtis Bay St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry D.Bayly.

(Residence in Baltimore: No. 1201 Light St. St.; 29 yrs., 8 mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced, (Write the word.): Divirced.

6-DATE OF BIRTH: September 1st. 1893. (Month) (Day) (Year)

7-AGE: 29 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pipe fitter.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry D.Bayly.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Mary Finn.

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin J.Bayly. (brother)

(Address) 2769 W.North Ave.

15. FILED MAY 7 - 1923. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4th. 1923. (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted by coming in contact with a portable electric lamp on s/s Cassiner.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

May 4th 1923 (Address) 1017 N.Charles st.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	5/8/23 19
20-UNDERTAKER	ADDRESS
Isiah Tyson 1660	N Dutch Gov

Spec. — 6-9-19 — H. P. Co. — 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75536

CERTIFICATE OF DEATH.

46 D75536

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2 Schley ave ST.: Gardenville (WARD)

2-FULL NAME Elizabeth Barbara Woerner

(a) RESIDENCE. No. 2 Schley ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married-

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: George Friedrich Woerner

6 DATE OF BIRTH (month, day, and year): Dec. 17, 1873

7 AGE: Years 49- Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: George Quick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Schone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Geo. F. Woerner

(Address) 2 Schley ave.

15 MAY 7-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1- 1922, to May 4, 1923, that I last saw h~~e~~ alive on May 4 1923 and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 1-

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical tissue examination

(Signed) Isa Bender, M. D.

May 7. 1923 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jerusalem Cemetery — DATE OF BURIAL: May 8 1923

20 UNDERTAKER: Josiah Syfer — ADDRESS: 1600 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75537

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D75537

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jakup Scezuk

(Residence in Baltimore: No. 717 Curtis Ave. St.; yrs. 18 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. unknown ..... 1..... (Month) (Day) (Year)

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country). "

12-MAIDEN NAME OF MOTHER. "

13-BIRTHPLACE OF MOTHER. (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A.Pacwicz

(Address) 715 Curtis Ave

15- Filed MAY 7 1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30/23 192.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia- cellulitis of lt. cervical reg. -infected tooth

(Autopsy at Hospital)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. ds.

(Signed) J S Falcon M. D. (Coroner)

5/7/23 192.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cem	May 8 1923
20-UNDERTAKER.	ADDRESS
Richard P. Curley	1108 Guilford Ave

Spec.—1-10-21—M&T—1500 Blks.

160857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 ✓

D75538

D75538

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Szczukowski

(a) RESIDENCE NO. 707 S. Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary

6 DATE OF BIRTH (month, day, and year) Aug 2 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	57	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records.

15 Filed MAY 7 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to May 6th, 1923, that I last saw him alive on May 6th, 1923, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Bladder

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan 26 1923

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Shaw, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	May 9 - 1923
20 UNDERTAKER	ADDRESS
M. F. Sadowski	705 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75539 HEALTH DEPARTMENT—CITY OF BALTIMORE D75539

CERTIFICATE OF DEATH.

3 101-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 430 S. Eden St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Julianna Gerecht

(a) Residence No. 430 S Eden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Unknown

14- (Informant) Mr Chas Gerecht

(Address) 1609 Bank St

15- Filed MAY 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 5-1923

17- I HEREBY CERTIFY, That I attended deceased from May 5th 1923 to May 5th 1923, that I last saw h. alive on May 5th 1923, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Franklin F Fleming M. D.

May 7th 1923 (Address) 1908 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel — DATE OF BURIAL, May 8 1923

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2000 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75540

CERTIFICATE OF DEATH.

101-00

D75540

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407. Eastern Ave ST., 3 (Grom) WARD)

2-FULL NAME John Grom

(a) RESIDENCE NO. 1407 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Grom.

6 DATE OF BIRTH (month, day, and year) June 24. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53 years	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laber.

(b) General nature of industry, business, or establishment in which employed (or employer) Box Factory.

(c) Name of employer Canton Box Co.

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER John Grom.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria.

14 Informant Francis Grom. (Address) 1407. Eastern Ave

15 MAY 7-1923 ROBERT R. KRANTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30 1923 to May 3 1923, that I last saw him alive on May 3 1923, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial cold (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine, M. D.

May 7, 1923 (Address) 14 S. Bussey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery.	May. 7 1923

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75541

CERTIFICATE OF DEATH.

38 D75541

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs Rose Bruty

(a) RESIDENCE NO. 660 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Philip Bruty

6 DATE OF BIRTH (month, day, and year): 1896

7 AGE: Years: 27 Months: Days: If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Patrick Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country): Texas Md

12 MAIDEN NAME OF MOTHER: Ida Trout

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Philip Bruty

(Address) 660 W. Franklin St Hosp

15 Filed MAY 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/4 1923

17

I HEREBY CERTIFY, That I attended deceased from 4/25, 1923, to 5/4, 1923,

that I last saw h[illegible] alive on 5/4, 1923,

and that death occurred, on the date stated above, at 1 40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis

(duration) ? yrs. mos ≠ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no Findings

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Aron Jordon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 5/8 1923

20 UNDERTAKER: George J Ruth

ADDRESS: 335 Harford Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Brazel

100-001

D75542

D75542

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Green Sts. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brazel

(a) RESIDENCE NO. Catholic Church, Towson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dennis Brazil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Father Sheridan
(Address) Catholic Church, Towson Md

15 MAY 7-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/5/23, 1923, to 5/5/, 1923,

that I last saw him alive on 5/5/, 1923,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? outside

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & lab. findings

(Signed) Leon Freedom, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Maria Towson	5/7/1923
20 UNDERTAKER	ADDRESS
J. Kelly Dana	1318 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Causey.

D75543

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D75543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2624 Frisby St

CITY OF BALTIMORE: (No.) 2624 Frisby ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edgar Causey

(a) RESIDENCE NO. 2624 Frisby ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Causey

6 DATE OF BIRTH (month, day, and year) Nov 19 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salesburry N C

12 MAIDEN NAME OF MOTHER Elnora Kiefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs E. L. Brooks

(Address) 2624 Frisby St

15 Filed MAY 7 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to May 5, 1923, that I last saw him alive on May 4, 1923, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual test

(Signed) C. E. L. Macdonald, M. D.

May 5, 1923 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	May 8, 1923
20 UNDERTAKER	**ADDRESS**
Joseph B Cook	1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75544

58-081 D75544

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3218 Westwood Avenue ST., 15 WARD)

2-FULL NAME Sallie O. McBride

(a) RESIDENCE No. 3218 Westwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 21st ~~1923~~ 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER James M. Mc Bride

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Olivia Willowby

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Miss Mabel Thomas
(Address) 3218 Westwood Ave

15 Filed MAY 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921 to May 6, 1923.
that I last saw her alive on May 5, 1923.
and that death occurred, on the date stated above, at 12.10 noon.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia about 2 years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis
(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Blood Examination

(Signed) Theodore H. Morrison M. D.

5/6, 1923 (Address) 1528 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
East New Market, Md.

DATE OF BURIAL
May 7th, 23

UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75545 HEALTH DEPARTMENT—CITY OF BALTIMORE D75545

CERTIFICATE OF DEATH.

REGISTERED NO. 67

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3226 E. Baltimore ST., 6 WARD)

2-FULL NAME Donald William Mitchell

(a) RESIDENCE NO. 3226 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 11, 1922

7 AGE: Years 1 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER Kenneth Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Estelle Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant Kenneth Mitchell (Address) 3226 East Balto St

15 MAY 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 7, 1923, that I last saw h[im] alive on May 6, 1923, and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH* was as follows: Broncho-Pneumonia, following Measles

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ellen C. Beckham M. D.

527, 1923 (Address) 3139 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cat Lawn

DATE OF BURIAL. May 8, 1923

20 UNDERTAKER: Wm. Cook

ADDRESS For E. Monument Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75546

CERTIFICATE OF DEATH.

93 D75546

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

2-FULL NAME Gilbert Wall

(a) RESIDENCE NO. 1807 Barclay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
over	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) Henry E. Wall

15 Filed MAY 7 - 1923 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 29, 1923, to May 6, 1923

that I last saw h[illegible] alive on May 6, 1923.

and that death occurred, on the date stated above, at 10.15 A.M.

The CAUSE OF DEATH* was as follows:

Hemangeoma of nose

(a) unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cavernous sinus thrombosis Orbital abscess. Streptococcus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of March 25

Was there an autopsy? yes (partial)

What test confirmed diagnosis? Clinical signs

(Signed) G. C. Halley, M. D.

5/6, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park, Kent Co. May 9, 1923

20 UNDERTAKER — ADDRESS

Wm Tenk for E Hartley

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75547

CERTIFICATE OF DEATH.

X 124

D75547
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST. 24 WARD)

2-FULL NAME Mrs Theresa Herbert

(a) RESIDENCE NO. Laurel Heights Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: married

5a ~~If married, widowed, or divorced~~ HUSBAND ~~of~~ (or) WIFE of: John L. Herbert

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 57; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): 131
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10 NAME OF FATHER: Unk Krum
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unk
12 MAIDEN NAME OF MOTHER: Unk
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unk

14 Informant: Mrs Harding
(Address) 1210 E Preston St

15 Filed MAY 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 29 1923, to May 6 1923,
that I last saw her alive on May 6 1923,
and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Chronic Chr Nephritis
(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Yes Date of May 4/23

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John D. Common, M. D.
, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 10 1923

20 UNDERTAKER: Wm. Cook for E. Norris — ADDRESS

Spec.—6-9-13—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75548

122-002

D75548

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 N. Charles ST.: 12 WARD)

2-FULL NAME Matthew Kavanaugh.

(a) RESIDENCE. NO. 1708 N. Charles. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary Kavanaugh

6 DATE OF BIRTH (month, day, and year) Sept 4-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Charles Kavanaugh.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret Brennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Anna Montaugh (Address) 1708 N. Charles St.

15 MAY 7-1923 ROBERT R. KRANTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 - 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24 - 1923, to May 7 - 1923, that I last saw him alive on May 5 - 1923, and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

atrophic cirrhosis of liver

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland. M. D.

5-7. 1923 (Address) 2532 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 9, 1923

20 UNDERTAKER ADDRESS

Wm. Cook for E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

None Alcoholic

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75549

CERTIFICATE OF DEATH.

128 D75549

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 821 E. Eager St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Donnelly

(Residence in Baltimore: No. 821 E. Eager St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Single

6-DATE OF BIRTH. unknown (Month) ..... (Day) 1..... (Year)

7-AGE.	If LESS than 1 day,
31 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer). Edgewood Arsenal

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS:

10-NAME OF FATHER. Patrick Donnelly

11-BIRTHPLACE OF FATHER. (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Muldoon

13-BIRTHPLACE OF MOTHER. (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret Donnelly

(Address) 821 E. Eager St

15- Filed MAY 7 - 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 5/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Nephritis

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) .....yrs. 30 mos. .....ds.

(Signed) J S Wade M. D. (Coroner.)

5/7/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem.	May 8 1923

20-UNDERTAKER.	ADDRESS
Henry Boucke & Son	1307 E. Eager St

D75550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75550

Registered No. C 170

1-PLACE OF DEATH

City of BALTIMORE: (No. 1042 N. Eden St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Braker

(Residence in Baltimore: No. 1042 N. Eden St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Correct word.)
male	white	widower

6-DATE OF BIRTH. March 22/1881 (Month) (Day) 1 (Year)

7-AGE. 42 yrs. 1 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Haberdasher
(b) General nature of industry, business, or establishment in which employed (or employer). for self

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Frank Braker

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Theresa Yaekel

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Herbert

(Address) 1042 N. Eden St

15- Filed MAY 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6/23 (Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide- pistol shot thru rt temple.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Pullen M. D. (Coroner.)

5/7/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. May 9 1923

20-UNDERTAKER. Henry Hoeck & Son ADDRESS 1301 E. Eager St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75551

CERTIFICATE OF DEATH.

D75551

REGISTERED NO. 134

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (WARD) 8

2-FULL NAME Mrs. Edna Williams

(a) RESIDENCE No. 2054 E. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. John Williams

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm J. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret Zink

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Mr. John Williams 2054 E. Hoffman St.

15 Filed MAY 7 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 5, 1923, that I last saw her alive on May 5, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

myocarditis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation - Hysterectomy.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 4/3/23

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward H. Kulawski M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 8th 1923
20 UNDERTAKER Robt F Turner Inc.	ADDRESS 1442 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75552

CERTIFICATE OF DEATH.

D75552

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 S 15th St. ST., 16 WARD)

2-FULL NAME George Weikel

(a) RESIDENCE NO. 300 S 16th St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Dobyle	Married

5a If married, widowed, or divorced HUSBAND of Mary T Weikel

6 DATE OF BIRTH (month, day, and year) Aug 27 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Same

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Dan Weikel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mary T Weikel. (Address) 300 S 15th St

15 MAY 7 - 1923 ROBERT W. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1923, to May 6, 1923, that I last saw him alive on May 6 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion.

(duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Liver

(duration) 1 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas K McTurley M. D.

(Address) 248 Se 20 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL May 9 1923

20 UNDERTAKER Robt J Turner Inc

ADDRESS 1442 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Form 12-23-21—E.P.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75553

CERTIFICATE OF DEATH.

D75553

1-PLACE OF DEATH

City of BALTIMORE: (No. 26 Poultney St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmine Hoerning

(a) Residence No. 26 Poultney St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles S. Hoerning

6-DATE OF BIRTH (month, day and year) Feb 2 1837

7-AGE. 86 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS

10-NAME OF FATHER. Joachim Handel

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14 (Informant) Mary S. Keefer

(Address) 26 Poultney St

15-

Filed MAY 7-1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6-23

17- I HEREBY CERTIFY, That I attended deceased from Apr 23 1923 to May 6 1923

that I last saw h.. alive on May 6 1923

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Injuries of eye

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) S Krauthoff M. D.

. 19 (Address) 1340 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL. May 8 1923

20-UNDERTAKER. F. R. Krause & Son ADDRESS 733 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75554

CERTIFICATE OF DEATH.

91-002

D75554

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 Dumbarton av ST., 9 WARD)

2-FULL NAME William B. Burkheimer

(a) RESIDENCE NO. 626 Dumbarton av ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Burkheimer

6 DATE OF BIRTH (month, day, and year) July 21-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Burkheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. Edelstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Sandrock (Address) 626 Dumbarton ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MAY 7 - 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1923, to May 6, 1923, that I last saw him alive on May 5, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio-Sclerosis

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no —

What test confirmed diagnosis? Clinical

(Signed) John S. Fenby M. D.

5/7, 1923 (Address) 3522 Greenmount ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	May 8 1923
20 UNDERTAKER	ADDRESS
F. A. Kramer & Son	703 Hanover

Spec.—1-10-21—M&T—1500 Bks.

D75555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75555

CERTIFICATE OF DEATH.

X 31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Morrow Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Faulkner

(a) RESIDENCE NO. Cambridge md ST., ... WARD Cambridge Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Marine

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cambridge md

PARENTS

10 NAME OF FATHER Edward Faulkner

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Patients History
(Address) Morrow Hosp.

15 MAY 7 - 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-30, 1923, to 5-5, 1923, that I last saw him alive on 5-5, 1923, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) P. E. Schorb, M. D.

5-6, 1923 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md — DATE OF BURIAL 5/7 1923

20 UNDERTAKER A. Guirus & Bro — ADDRESS 1127 E Balto St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAGE
mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75556

CERTIFICATE OF DEATH.

90 D75556

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1307 Homewood Av. (ST.) 9 (WARD)

2-FULL NAME Laurence Keene

(a) RESIDENCE NO. 1307 Homewood Av. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 93 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? Life. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) the late Mary E. Keene

6 DATE OF BIRTH (month, day, and year) Dec. 25 1829

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Cooper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Martin J. Keene (Address) 1307 Homewood Av

15 MAY 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922, to May 6, 1923, that I last saw h[im] alive on May 6, 1923, and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 hour ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) 2 1/2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred B. Speight, M. D.

5/7, 1923 (Address) 2035 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peter's Cemetery	May 9 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	130, E Eager St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75557

CERTIFICATE OF DEATH.

162 D75557

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 16 WARD)

2-FULL NAME Baby Potter

(a) RESIDENCE NO. 1014 N. Carey St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 20 / 23

7 AGE — Years: — Months: — Days: 2 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Carrol Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hattie Potter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) W. W. Gray Johns Hopkins Hospital.

15 Filed ... 19 ... Registrar

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1923, to April 21, 1923, that I last saw h[e]r alive on April 21, 1923, and that death occurred, on the date stated above, at 1 10 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) W. W. Gray, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

20 UNDERTAKER —

DATE OF BURIAL 19 23

ADDRESS —

MAY 7 - 1923

Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75558 HEALTH DEPARTMENT—CITY OF BALTIMORE D75558

CERTIFICATE OF DEATH. X 122 .002

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Pereira

(a) Residence No. 660 Calder St., Ward Harrisburg, Pa.
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ? ? 1873

7-AGE. 50 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS.
10-NAME OF FATHER, Jesus Pereira
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria
12-MAIDEN NAME OF MOTHER, ?
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria

14- (Informant).....
(Address).....

15- Robert F. Harrison, UNIVERSITY OF MARYLAND, 192... Registrar.

MAY 7 1923

Burial Permit Clerk

0356

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3 1923

17- I HEREBY CERTIFY, That I attended deceased from April 23 1923 to May 3 1923.
that I last saw h. alive on May 3 1923.
and that death occurred, on the date stated above, at 2 A.M. P.M.
The CAUSE OF DEATH* was as follows:
Thrombus Cerebri
liver
(Duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage from Bowel (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No Signs
What test confirmed diagnosis?
(Signed) A. J. Smagner M. D.
, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, 19...

20-UNDERTAKER. Commissioner Health, ADDRESS. MAY 7 1923
Per: Wm. E. Woodall

8—WRITE PLAINLY, WITH UNFADING INK. All items stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be stated carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Non Alcoholic
See Letter from M. Ivanoff.
6/27/23.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75559

CERTIFICATE OF DEATH.

D75559

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1404 Riggs Ave ST. 16 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Grant

(Residence in Baltimore: No. 1404 Riggs Ave St.: yrs., 7 mos. 15 ds.)

WRITE PLAINLY, WITH UNFADING INK.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, Oct 21, 1915 (Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Errand boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Saml Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Beatrice Grant

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beatrice Grant

(Address) 1404 Riggs Ave

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAY 7 - 1923

0355

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs....mos....ds.

(Signed) J. F. Hemmeter, M. D. (Coroner.)

May 5, 1923 (Address) 3503 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND DATE OF BURIAL, ... 19....

20-UNDERTAKER Commissioner Health, ADDRESS

FUNERAL DIRECTOR Wm. H. WOODALL

MAY 7 - 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75560

D75560

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 419 S. East ave. ST., WARD)

2-FULL NAME George Martin

(a) RESIDENCE NO. 419 S. East ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Agnes Martin

6 DATE OF BIRTH (month, day, and year) Dec 20 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	44	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairy Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Milk

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER John Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Agnes Martin

(Address) 419 S. East ave.

15 Filed ..... 19 .....

Robert F. McAleer

Burial Permit Clerk. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

7-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1923, to May 5, 1923, that I last saw him alive on May 4, 1923, and that death occurred, on the date stated above, at 7 50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Insufficiency

following Rheumatism

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation + Urinary

(Signed) Frank A Glantz, M. D.

May 6 1923 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 5/7/1923

20 UNDERTAKER J. G. Moran

ADDRESS 3000 E. Biddle St.

Spec.—1-10-21—M&T—1500 Blks.

D75561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75561

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 E. Hill St. ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Brannan.

(a) RESIDENCE NO. 40 E. Hill St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 6th. 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Brannan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Eliza J. Kennedy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Thomas Brannan. (brother)

(Address) 1729 Bolton St.

15 Filed Robert P. Harrison, Registrar

MAY 7-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th. 1923.

17

I HEREBY CERTIFY, That I attended deceased from April 2kth 1923, to May 6th. 1923.

that I last saw him alive on May 5th. 1923.

and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Apnoea.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ------

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Otto M Reinhardt, M. D.

5/6. 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 8 1923
20 UNDERTAKER John F. Kenny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should note
AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D75562 HEALTH DEPARTMENT--CITY OF BALTIMORE D75562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 416 N Fremont St., 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J Pratt

(Residence in Baltimore: No. 416 N Fremont St.; 74 yrs., ~ mos., ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. March 4 1848 (Month) (Day) (Year)

7-AGE. 74 yrs. 2 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Fairfield Vermont

PARENTS.

10-NAME OF FATHER. C. J. Pratt

11-BIRTHPLACE OF FATHER, (State or Country) Sudbury Vermont

12-MAIDEN NAME OF MOTHER, Sarah Jane Warren

13-BIRTHPLACE OF MOTHER, (State or Country) Sudbury Vermont

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert E. Statham

(Address) 1830 Lanvale St Paul

15- MAY 7 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Probably a few hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. mos. ds.

(Signed) H K Tousley M. D. (Coroner.)

5-5 1923 (Address) 41 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	May 8 1923

20-UNDERTAKER.	ADDRESS
Chas. G. Black	742 W. Ninety ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1050 Blks.

D75563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75563

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2857 Penna Ave ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret F Porter

(a) RESIDENCE. NO. 2857 Penna Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Porter

6 DATE OF BIRTH (month, day, and year) Sept. 24. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rock Hall. Maryland

PARENTS

10 NAME OF FATHER Frank McKnett

11 BIRTHPLACE OF FATHER (city or town) Havre de Grace (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha A. Bowers

13 BIRTHPLACE OF MOTHER (city or town) Rock Hall (State or country) Maryland

14 Informant Wm. J. Porter (Address) 2857 Pennsylvania Ave

15 MAY 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1923

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to May 6, 1923, that I last saw h-e alive on May 5, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Asthma

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 3/15/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gambrill, M. D

1923 (Address) 517 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley Chapel Rock Hall Md	May 9 1923
20 UNDERTAKER	ADDRESS
Horace H. Burgee	363 Halls Rd

B—WHITE PAPER, WHITE INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See Letter attached) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75564

CERTIFICATE OF DEATH.

90 D75564

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Hanneman Ave ST.: 8 WARD)

2-FULL NAME Anton Mazzis

(a) RESIDENCE. NO. 1804 Hanneman Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Mazzis

6 DATE OF BIRTH (month, day, and year) about 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66 ~~70~~ ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Frances Retz (Address) 1804 Hanneman Ave

15 Filed MAY 7-1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1. 1923 to May 5. 1923 that I last saw him alive on May 4. 1923 and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows: Cardiac asthma — Mitral Regurgitation

CONTRIBUTORY (Secondary) Acute Edema of Lungs (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No findings

What test confirmed diagnosis? ~~Internal~~ Clinical

19 (Address) 600 N Patterson Park Ave M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 9. 1923

20 UNDERTAKER Frank Crockett — ADDRESS 1906 Orleans St

M. B.—WRITE PLAINLY. All questions must be answered. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION may be properly classified, so that it may be coded. See back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

DR. F. FREDERICK RUZICKA
800 N. PATTERSON PARK AVE.
BALTIMORE, MD.

PHONE WOLFE 4127

OFFICE HOURS:
8 TO 9 A. M., 6 TO 8 P. M.

6— 22—20

Dr Jones,

Please correct age & date
ances Hoffig from 72 yr to
66 yr which was stated in err

Respectfully Submitted

F F Ruzicka

RE

[Approve

State
occupat
healthf
questio
pective
or term
Farmer
teet, La
fireman
trial er
kind of
or indu
vided f
when n
mill; (c
Automo
form p
"Labor
without
Farm l
home, v
only (r
salary)
or *At h*
At sch
report
in dom
Housen
or give
state o
from t
Farmer
occupat

State
DISEASE
respect
same a
Cerebr
"Epide
(avoid
port "
Bronch
indefini
tonetum
(name
"Tuno

t disease;
ntributory
ed not be
s (disease
u (second-
r terminal
" (merely
ma," "Con-
ile," etc.),
, "Hemor-
"Shock,"
ite disease
qualify all
rriage, as
rtionitis,"
ation was
MEANS OF
ICIDAL, or
ossible to
al drown-

Revolver
rbolic acid
injury, as
g., *sepsis,*
"contribu-
f cause of
clature of

MENTS

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75565

CERTIFICATE OF DEATH.

129

D75565

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N Collington ST.: 7 WARD)

2-FULL NAME. Ferdinand F. Rob

(a) RESIDENCE. NO. 714 N. Collington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Rob

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Garage owner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Kajetan Rob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohmia

14 Informant Frances Rob (Address) 714 N Collington

15 Filed MAY 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 1923 to May 6 1923 that I last saw him alive on May 5 1923, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis,
Hypertension
Acute Uraemia 4 ds.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pending Wassermann

(Signed) [illegible] M. D.

, 19 (Address) 800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 8. 1923

20 UNDERTAKER East Encebon — ADDRESS 1906 Eastern Ave

WRITE PLAINLY. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

(Vyskocil)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75566

CERTIFICATE OF DEATH.

D75566

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. Hospital ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanya Zuzy Kocil.

(a) RESIDENCE No. Hendenson. md ST., WARD Glenburnie Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: Mute.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years | Months: 6 | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joseph Vyskocil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mary Vyskocil

(Address): Hendenson

15 Filed ....., 19.... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 1923

17

I HEREBY CERTIFY, That I attended deceased from May 6. 1923 to May 7 1923.

that I last saw him alive on May 6 1923.

and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH* was as follows: —

Malnutrition

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hendenson

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? None.

(Signed) John Adriaans, M. D.

19 (Address) Sanatorium Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross G.C. Balto

DATE OF BURIAL: May 8 1923

20 UNDERTAKER: Chas. L. Cracken

ADDRESS: 1906 E. Balto

MAY 7 - 1923

Spec.—1-10-21—M&T—1500 Blks.

D75567 HEALTH DEPARTMENT—CITY OF BALTIMORE D75567

CERTIFICATE OF DEATH.

REGISTERED NO. 74001

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 2447 Barclay St ST., 12 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline L. Wagner

(a) RESIDENCE NO. 2447 Barclay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ (or) WIFE of ~~HUSBAND~~

6 DATE OF BIRTH (month, day, and year) Apr. 16 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	82	—	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Henry Sellman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Caroline Grace
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Ada Kauffman
(Address) 2447 Barclay St

Filed May 7 1923 Robert P. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 23 1923 to May 5 1923.
that I last saw her alive on May 4 1923,
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (duration) 12 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wallis W. White Jr. M. D.
5/5 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Baltimore Md
20 UNDERTAKER H M Routson

DATE OF BURIAL May 8 1923
ADDRESS 2235 W North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU- TION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75568

CERTIFICATE OF DEATH.

60-00

D75568

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., ... WARD)

2-FULL NAME Mrs. Celia Worshaw

(a) RESIDENCE NO. 3522 Park Heights Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred abt 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Unknown yrs. ..... mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Worshaw.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Russia.

PARENTS

10 NAME OF FATHER Jacob Worshaw

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Lilie Worshaw

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant Hospital Records.
(Address)

15 MAY 7 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1923, to May 7, 1923, that I last saw h[illegible] alive on May 7, 1923, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Toxic Goitre

Duration yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

Duration yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of May 4, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) B. M. Kahn M. D.

5-7, 1923 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Borow. Dr. Hirsch N.Y. Statistics

DATE OF BURIAL May 8/ 1923

20 UNDERTAKER Walter Davis

ADDRESS 337 Park

B.—WRITE PLAINLY with unfading ink. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

75569
D75569

CERTIFICATE OF DEATH.

4 X 44 D75569

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Franklin Chaney

(a) RESIDENCE NO. Bristol, Ann Arundel Co. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ——— yrs. ——— mos. 9 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Nellie Chaney

6 DATE OF BIRTH (month, day, and year): July 15, 1858

7 AGE — Years: 64 — Months: 9 — Days: 13 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): Farming

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Joseph Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Jane Drury

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Joseph Chaney (Address) Bristol, Md.

15 MAY 8 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28, 1923. to May 7, 1923.

that I last saw him alive on May 7, 1923.

and that death occurred, on the date stated above, at 10.35 p.m.

The CAUSE OF DEATH* was as follows:

Abdominal Carcinomatosis.

Duration ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Cardiac Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of Apr. 30, 1923

Was there an autopsy? No Operation.

What test confirmed diagnosis?

(Signed) B. M. Rhodes, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md.

DATE OF BURIAL: May 8 1923

20 UNDERTAKER: Jas. S. Taylor Sons

ADDRESS: Annapolis Md.

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer of Stomach

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75570

CERTIFICATE OF DEATH.

88 D75570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat (St.) 28 (Ward)

2-FULL NAME Mrs Sophie M. White

(a) RESIDENCE. (No.) Mt Hope Retreat (St.) 28 (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 0 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Mr White

6 DATE OF BIRTH (month, day, and year) July 5 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	25	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Lerber

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mrs Myers

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Maryland

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md

15 Filed MAY 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 - 1922, to May 4th - 1923.

that I last saw her alive on May 4 - 1923.

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis -

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Chr. Man. Dpsn. Tachoma - (Post Puerperal) (duration) 1 yrs. 10 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

May 5 - 1923 (Address) Mt Hope Retreat Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 8 - 1923

20 UNDERTAKER Lilly & Zuber — ADDRESS 4033 Wolfe St

NOTICE—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D75571

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 W. Glen Ave ST., 27 WARD)

2-FULL NAME Thomas Neuberger

(a) RESIDENCE NO. 14 W. Glen ave ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine W. Neuberger

6 DATE OF BIRTH (month, day, and year) April 29th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Katharine W. Neuberger (Wife) (Address) 14 W. Glen Ave

15 Filed MAY 8 - 1923 ROBERT K. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923 to May 6, 1923 that I last saw him alive on May 4, 1923 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pressman M. D.

6.7.23. (Address) Tan Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 9 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4033 S. Wolfe

Spec.—1-10-21—M&T—1500 Blks.

D75572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75572

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2715 Hudson ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Hasenei.

(a) RESIDENCE NO. 2715 Hudson ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Hasenei.

6 DATE OF BIRTH (month, day, and year) April 12 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Hasenei.

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Haas.

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Annie E. Hasenei. (Wife)
(Address) 2715 Hudson St.

15 Filed MAY 8 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to May 5, 1923,
that I last saw him alive on May 4, 1923,
and that death occurred, on the date stated above, at 1.05 P. m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb N. Athey, M. D.

May 5 1923 (Address) 100 S. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	May 8 1923
20 UNDERTAKER	**ADDRESS**
Lilly & Zeiler	403 S. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75573

CERTIFICATE OF DEATH.

46 D75573

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N. Kenwood ave. WARD) 6

2-FULL NAME Mary J. Reis.

(a) RESIDENCE NO. 206 N. Kenwood ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August W. Reis.

6 DATE OF BIRTH (month, day, and year) April 2nd 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Edwd. Harrold.

11 BIRTHPLACE OF FATHER (city or town) Eng.
(State or country)

12 MAIDEN NAME OF MOTHER Brigit M. Martin

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant August W. Reis Husband
(Address) 206 N. Kenwood ave.

15 Filed MAY 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/1/23, 19..., to 5/6/23, 19..., that I last saw her alive on 5-6-23, 19..., and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Sarcoma Uterus

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What (test confirmed diagnosis?

(Signed) F. J. Hewman M. D.

5/7/23 (Address) 2914 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 9 1923
20 UNDERTAKER	**ADDRESS**
Lilly & Geiler	400 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D75574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75574

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 street - (Read st St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Sabitino

(Residence in Baltimore: No. 1400 Block Bank st - St. (yrs., 25 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~ (Write the word.) married

6-DATE OF BIRTH, Sept (Month) 12 (Day) 1875 (Year)

7-AGE, 47 yrs. 8 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of Industry, business, or establishment In which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Salvator Sabitino

11-BIRTHPLACE OF FATHER, (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Rosa Bineza

13-BIRTHPLACE OF MOTHER, (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emanuel D'Linea

(Address) 107 S High St

15-

Filed MAY 8 - 1923 ROBERT R. KRAUTER, Register.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(~~Inquest~~, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
Pneumonia
(Duration) 1 day mos. ds.

CONTRIBUTORY (Secondary) Probably Tuberculosis
(Duration) yrs. mos. ds.

(Signed) W. F. Gamble M. D.
(Coroner)

5-7 1923 (Address) 1131 W. Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery DATE OF BURIAL, 5/9 1923

20-UNDERTAKER, George J. Ruth ADDRESS 1735 Hanover Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75575

CERTIFICATE OF DEATH.

90 D75575

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. # 1225 E. Biddle St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Annie C. Brennan

(a) Residence No. 1225 E. Biddle St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Brennan

6-DATE OF BIRTH (month, day and year) 6/20/1860

7-AGE, 62 ....yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... Unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Unknown (State or Country),

14-

(Informant)..... Mrs. L. Krauter

(Address).... 12 Bayon Ave. Hamilton

Filed MAY 6-1923 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 4 1923, to May 5, 1923, that I last saw h[illegible] alive on May 5, 1923, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY —
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D Heck, M. D.

May 7, 1923 (Address) 936 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral — DATE OF BURIAL, 5/8/, 1923

20-UNDERTAKER, George J Ruth — ADDRESS 1750 Harford Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must use ONLY the terms in the International Classification. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75576

HEALTH DEPARTMENT—CITY OF BALTIMORE

51 D75576

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. STREET OR WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Badinger

(a) RESIDENCE NO. 413 Gilsborough Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Philip Badinger

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Herin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Manie Badinger (Address) 413 Gilsborough Ave

15 MAY 8-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1923

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1923. to May 5, 1923.

that I last saw her alive on May 5, 1923.

and that death occurred, on the date stated above, at 4.05 A.m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary edema and meningismus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Krager, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 5/8 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS' AGE should be stated EXACTLY. mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute Rheumatic Fever

Spec.—1-10-21 M&T 1500 Bks.

D75577

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75577

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 West 27th. Street ST. 17 WARD)

2-FULL NAME Augustus G. Stollenwerck

(a) RESIDENCE NO. 8 Crawford Circle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 1 mos. 0) ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Anderson

6 DATE OF BIRTH (month, day, and year) Oct. 18, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	52	6	18	

8 OCCUPATION OF DECEASED Investments

(a) Trade, profession or particular kind of work Bond Brooker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Hemphill, Noyes & Co.

9 BIRTHPLACE (city or town) (State or country) Selma, Alabama

PARENTS

10 NAME OF FATHER Augustus Stollenwerck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Selma, Alabama

12 MAIDEN NAME OF MOTHER Julia F. Fowlkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Selma, Ala.

14 Informant Edw. Carroll Stollenwerck
(Address) 25 Broad St., New York

15 MAY 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to May 6, 1923, that I last saw him alive on May 6, 1923 and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
(Heart failure)

about (duration) — yrs. 3 or 4 mos — ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Physical Examination

(Signed) Robert Street, M. D.

, 19 (Address) 712 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lawnwood Cem. DATE OF BURIAL May 8 1923

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 Calvert St

Spec.—1-10-21—M&T—1500 Bks.

D75578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D75578

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3223 Elliott ST. Ho WARD)

2-FULL NAME Baby Rabyczki

(a) RESIDENCE NO. 3223 Elliott ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1923

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew Rabyczki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Tillie Solezyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Tillie Rabyczki (Address) 3223 Elliott

15 Filed MAY 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7 23, to May 7 23.

that I last saw h- alive on May 7 23

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Kath Insley M. D.

, 19 (Address) 2235 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May 8 1923
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. AGE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75579

CERTIFICATE OF DEATH.

129

D75579

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 N Bond ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Cozy

(a) RESIDENCE. NO. 530 N Bond St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	-	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) S. C.
(State or country) ~~Georgia~~

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Rachel Cozy
(Address) 530 N Bond St

15 Filed MAY 8 - 1923 ROBERT P. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 23, 1923, to May 5, 1923, that I last saw h- alive on May 5, 1923, and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) - yrs. ✓ mos. 12 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

Independent (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

5-5 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	May 9 1923
20 UNDERTAKER	ADDRESS
R E Gross	1405 McElderry

N. B.—WHITE PAPER CERTIFICATE. AGE should be carefully supplied. Age information should be stated EXACTLY. Exact statement of OCCUPATION should be given so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500-3lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75580

129 D75580

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 N. Bentalou St. WARD 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma McGraw

(a) RESIDENCE No. 609 N. Bentalou St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjiman McGraw

6 DATE OF BIRTH (month, day, and year): Oct 18 187

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: Andrew Gerisch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Margaret Hamrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: Benjiman McGraw

(Address) 609 N. Bentalou

15 Filed — 8 [illegible] ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to May 6, 1923, that I last saw h[illegible] alive on May 6, 1923, and that death occurred, on the date stated above, at 8 [illegible] m.

The CAUSE OF DEATH* was as follows:

Anemia Coma

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tumor Left Abdomen

Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemy	May 9 1923
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2178 E. Pra

B.—WRITE plainly. All information should be carefully supplied. AGE should be stated EXACTLY. THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75581 ✓ D75581

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Eden Hall 3401 Greenmount Av. WARD 17)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew S. Brennan

(a) RESIDENCE No. Eden Hall apts ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Man	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Grace V Brennan

6 DATE OF BIRTH (month, day, and year) Sept 26 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Life Insurance

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Louis Oliver Brennan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) France

12 MAIDEN NAME OF MOTHER Louise Bennett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Elizabeth C. Sappington
(Address) Eden Hall 3401 Greenmount Av

15 Filed MAY 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1923, to May 6, 1923,
that I last saw him alive on May 6, 1923,
and that death occurred, on the date stated above, at 10 30 p m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1½ yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julian P. Friedenwald, M. D.

May 7, 1923 (Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 9th 1923
20 UNDERTAKER	ADDRESS
Henry W. Jenkins' Sons Co	Orchard & McCulloh Sts

N.B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75582

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Milton Ave. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Marie Guerin

(a) RESIDENCE NO. 1308 Milton Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16-1923

7 AGE — Years — Months — Days: 22 — If LESS than 1 day, ...hrs or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mathew Guerin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Marie Fryer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mathew Guerin

(Address) 1308 N. Milton Ave

15 Filed 8-1923, 19... Robert F. [illegible]

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8 1923

17

I HEREBY CERTIFY, That I attended deceased from 4/29, 1923, to 8-8, 1923,

that I last saw h... alive on 8-6, 1923,

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from umbilicus

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Jaundice of newborn

(duration) life yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Wells, M. D.

8/8, 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. — DATE OF BURIAL: May 8 1923

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmt Ave

N. B.—WRITE PLAINLY. PENCIL MUST NOT BE USED. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN filling CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75583

CERTIFICATE OF DEATH.

159-002

D75583

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1259 Washington Blvd ST., 21 WARD)

2-FULL NAME Marlin Estelle Bell

(a) RESIDENCE NO. 1259 Washington Blvd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 25" 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Frank A. Bell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Mc Cormick

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Frank A. Bell

(Address) 1259 Washington Blvd.

15 Filed MAY 8 1923 19..... Robert P. Harrison, Registrar

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH CARE. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSES is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7" 19 23

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to May 7, 1923.

that I last saw h[illegible] alive on May 7, 1923.

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Failure of Forceps
cradle to close

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Doscin, M. D.

5/7/ 19 23 (Address) 1227 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 9" 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75584

CERTIFICATE OF DEATH.

98 D75584

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 908 N. Bentalou St. ST., 16 WARD)

2-FULL NAME Sarah Ellen Ford

(a) RESIDENCE NO. 908 N. Bentalou St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. A. Ford

6 DATE OF BIRTH (month, day, and year) Sept. 3rd 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. E. Parks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant John Potter
(Address) 908 N. Bentalou St.

Filed MAY 8 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6 . 1923 . to May 7 - . 1923 .

that I last saw her alive on May 7 . 1923 .

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency .

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute indigestion .

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Bowman Lockard M. D.

5/8. 1923 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Somerset Co Md Fair Mount	May 9 1923
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W Balto St

WRITE PLAINLY, with ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

D75585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D75585

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2635 Dulaney ST. 20 WARD)

2-FULL NAME Infant + Talalay

(a) RESIDENCE NO. 2635 Dulaney ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): MAY 5 23

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day, 7 hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Alfred Talalay

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Katie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Elkton Md

14 Informant (Address): Katie Talalay 2635 Dulaney St

15 Robert F. Harrison, ... 19 ..... Registrar

Burial Permit Clerk.

MAY 8 1923

B.—WRITE PLAINLY, with ink. PHYSICIAN'S ... mation should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1923

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1923, to May 5, 1923.

that I last saw him alive on May 4, 1923.

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Prematur Birth

(7 months)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) James A Kaufmann M. D.

5/7, 1923 (Address) 1729 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: May 8 1923

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1863 N Gilmor St

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75586

CERTIFICATE OF DEATH.

90 D75586

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 418 Mott (St.) 5 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Robinson

(a) RESIDENCE NO. 418 Mott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lizzie Robinson

6 DATE OF BIRTH (month, day, and year): Mar 1st 1853

7 AGE — Years: 70 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Veterinarian

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: George Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lizzie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Estella Dejoan

(Address): 418 Mott Street

15 Date: MAY 8—1923 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/8/ 1923, to May 6 1923.

That I last saw h[illegible]ive on May 6, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Mitral regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson M. D.

5/8/ 1923 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: May 9 1923

20 UNDERTAKER: Mrs A G. Elliott — ADDRESS: 1725 Eastlander

MAY 8—1923

Information should be carefully supplied. AGE should be stated EXACTLY. Answers may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-001

D75587

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 S. Third ST., 26 WARD)

2-FULL NAME. May Eleanore Deter

(a) RESIDENCE NO. 808 S. Third ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harry W. Deter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Eleanore Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Eleanore Deter — (Address) 808 S. 3rd St.

15 Filed MAY 8 1923, 19.... Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1923, to May 7, 1923, that I last saw her alive on May 7, 1923, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Hydrocephalus

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. L. Kirkbride Co, M. D.

, 19 (Address) 806 S. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem.

DATE OF BURIAL May 8 1923

20 UNDERTAKER Lilly and Zeile

ADDRESS 403 S. Wolfe St.

IMPORTANT—WRITE PLAINLY. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. THIS CERTIFICATE may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75588

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75588

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 Madison ave St. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R McLaughlin

(a) RESIDENCE No. 1824 Madison ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Georgetta Ryder

6 DATE OF BIRTH (month, day, and year) 7/8/1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accomptiller

(b) General nature of industry, business, or establishment in which employed (or employer) 060

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Thos McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant (Address) Mrs McLaughlin 1824 Madison ave

15 Filed 8-1923 Robert P. Harrison, Registrar

Daniel Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6- 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1923, to May 6, 1923, that I last saw him alive on May 6, 1923, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia 4 days

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

Fatal (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No knowledge

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys signs

(Signed) C Untersmith, M. D.

19 (Address) 817 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	5/9 1923
20 UNDERTAKER	ADDRESS
Sam'l Tally & Sons	318 Light St

N. B.—WARNING—This information should be carefully supplied. AGE should be stated EXACTLY. Ill-considered answers to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

75587 D75589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D75589

1-PLACE OF DEATH St Vincents Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. 1401 Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Marlin

(a) RESIDENCE NO. 1401 Division St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St Vincent Infirmary (Address) 401 Division

15 Filed MAY 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to May 7, 1923

that I last saw him alive on May 7, 1923

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudenhead

DATE OF BURIAL 5/8 1923

20 UNDERTAKER Martin Fahey Son

ADDRESS 1827 W North

NOTICE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

7555 89

D75590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

83 D75590

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4138 Pimlico Road ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Johnson

(a) RESIDENCE. No. 4138 Pimlico Road ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Johnson

6 DATE OF BIRTH (month, day, and year) Feb 15 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 063

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Leo Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Catherine Johnson

(Address) 4138 Pimlico Road.

15 Filed MAY 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 20. to May 6 19 23.

that I last saw h. living on May 5 19 23.

and that death occurred, on the date stated above, at 11.15 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm M. Firth, M. D.

5/7 19 23 (Address) 2438 Mary Land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md.	May 9 19 23

20 UNDERTAKER E. A. Wiedefeld Jr

ADDRESS 501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

12859 D75591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003 D75591

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 S. Glover ST., 1 WARD)

2-FULL NAME Henry Lentz

(a) RESIDENCE NO. 721 S. Glover ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8 - 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Lentz

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hutton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Henry Lentz
(Address) 721 S. Glover St

15 Filed MAY 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1923, to May 8, 1923, that I last saw he alive on May 8, 1923, and that death occurred, on the date stated above, at 12 p m.

The CAUSE OF DEATH* was as follows: IV.

Blue baby.

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of ...

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) O L Long, M. D.

5/8. 1923 (Address) 2701 Eastwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	May 8 1923
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Pratt St

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. If CHILDREN, the number of years, months and days may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75592

D75592

CERTIFICATE OF DEATH.

REGISTERED NO. 7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 823 N Rose ST.: 7 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Soul

(a) RESIDENCE. NO. 823 N Rose ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Alois Soul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mary Bloyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Alois Soul 823 N Rose St

15 Filed MAY 9 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7 1923 to May 7 1923

that I last saw h alive on May 7 1923

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Scott M. D.

M. D. (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 9 1923

20 UNDERTAKER Enoch Evans Son

ADDRESS 1906 Eastern Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D75593

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 E. Hoffman ST., 8 WARD)

2-FULL NAME William J Crose

(a) RESIDENCE NO. 1514 E. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena S Crose

6 DATE OF BIRTH (month, day, and year) April 5 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Pol

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edward Crose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ellen Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Catherine Lambert 1514 E Hoffman

15 FILED MAY 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1923, to May 7, 1923, that I last saw him alive on May 6, 1923, and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) John H Ormm, M. D.

May 8, 1923 (Address) 35-a Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville — DATE OF BURIAL Nov 10 1923

20 UNDERTAKER Hmm Cook 502 E Lexington — ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. Abbreviations CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75594 ✓ D75594

CERTIFICATE OF DEATH.

23

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. Maryland General Hospital ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. Anderson

(a) RESIDENCE NO. 229 W Woodland Ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura Anderson

6 DATE OF BIRTH (month, day, and year) May 3, 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer) Underwood T. Co
(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Va

PARENTS
10 NAME OF FATHER —
11 BIRTHPLACE OF FATHER (city or town) —
(State or country)
12 MAIDEN NAME OF MOTHER —
13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Frank L. Hall
(Address) 132 Lakeside St

15 Filed MAY 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17
I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 7, 1923, that I last saw him alive on May 7, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalatis

(duration) yrs. mos 9 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy & Clinical
(Signed) James Hubert Wilkerson M. D.
19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 10, 1923

20 UNDERTAKER
Wm. Cook for E. Monk & Son
ADDRESS

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75595

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75595

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4339 York Road (ST.), 57 WARD)

2-FULL NAME Clara V. Botterill

(a) RESIDENCE NO. 4339 York Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Nicholas V. Botterill

6 DATE OF BIRTH (month, day, and year): June 8 1862

7 AGE — Years: 60 — Months: 11 — Days: ... — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Albert G Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky

12 MAIDEN NAME OF MOTHER: ? Swindall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Nicholas V. Botterill
(Address) 4339 York Road

15 MAY 9-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 22nd, 1923, to May 7th, 1923,

that I last saw h e alive on May 7th, 1923,

and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Gangrene of left leg 2 mos. Accidentally noticed

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) A. Ellis, M. D.

May 8th 1923 (Address) 24 E Mony

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dearmont — DATE OF BURIAL: May 9th 1923

20 UNDERTAKER: Wallace Cook — ADDRESS: 502 E Nav.

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. Answers to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Douglas
830 North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75596

CERTIFICATE OF DEATH.

90 D75596

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 411 E. Lafayette St. (WARD) 10

2-FULL NAME Lewis Small

(a) RESIDENCE NO. 411 E. Lafayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna S. Small

6 DATE OF BIRTH (month, day, and year) Oct 9 - 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 915

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer P. R. R. Co

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER ? ? ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anna Fry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Anna S Small

(Address) 411 E. Lafayette

15 MAY 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10th, 1923, to May 8th, 1923, that I last saw him alive on May 7th, 1923, and that death occurred, on the date stated above, at 1.25 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Heart Lesion
— Regurgitant —
— (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) arteriosclerosis (duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Eugene Douglas, M. D.

, 19 (Address) 830 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Strausburg Penna

DATE OF BURIAL May 11 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75597

CERTIFICATE OF DEATH.

76 38 D75597

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph Vickers .....

(a) Residence No. Unknown St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, ? Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1862

7-AGE. 60 yrs. ..... mos. ..... If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) ..... (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Joseph Vickers

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Mary Pickett

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) Maryland

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed MAY 9 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 8, 1923 to May 6, 1923 that I last saw h.. im alive on May 6, 1923 and that death occurred, on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) 30 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. McKay, M. D

5-7-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL. May 9, 1923

20-UNDERTAKER. M. J. Flynn ADDRESS 1422 Light St

should be carefully supplied. Exact statement of OCCUPATION is very important. Give in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D75598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75598

CERTIFICATE OF DEATH.

122-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 N. Fulton Avenue WARD 15)

2-FULL NAME Andrew J. Stall

(a) RESIDENCE. No. 1624 N. Fulton Avenue WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brick-Layer

(b) General nature of industry, business, or establishment in which employed (or employer): Erecting Buildings

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Alex Stall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah J. Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mrs James Bowersox 1624 N Fulton Avenue

15 Filed MAY 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15 1923. to May 6th 1923. that I last saw him alive on May 6th 1923. and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Atrophic Cirrhosis of the Liver (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Clinical

(Signed) Wm Fuller Carr, M. D.

5/8. 1923 (Address) 1701 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 9 1923

20 UNDERTAKER: E LeRoy Stiffler ADDRESS: 1258 North Ave

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Alcoholic

Spec.—12-23-21—E.B.P.S.—400 Blks.

D75599

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75599

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2502 W. Fairmount Ave. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Morris

(a) Residence No. 2502 W. Fairmount Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Male.	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Febry 8th 1892

7-AGE.	If LESS than 1 day.
..... yrs. ..... mos. 3 ds.	....hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Clerk. 004

(b) General nature of industry, business, or establishment in which employed (or employer)..... B & O R R.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER John J Morris

11-BIRTHPLACE OF FATHER (city or town) .....
(State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Bridget Lavin

13-BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Ireland

11- (Informant) Mrs Bridget Morris

(Address) 3502 W Fairmount

13- FILED MAY 9 - 1923 ROBERT N. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 8, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 28, 1923 to May 8, 1923

that I last saw h. alive on " " 1923

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

.....

.....

.....

.....(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Dilatation Of Heart

.....(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of "

Was there an autopsy?.....

What test confirmed diagnosis? Clinical

(Signed) John J Copeland, M. D.

5/8, 1923 (Address) 24 E. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL, May 11 a., 1923

20-UNDERTAKER Edward Gowan & Son ADDRESS 901 Hollins

Dr P J Gowan

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75600

CERTIFICATE OF DEATH.

44

D75600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Sargeant ST., 21 WARD)

2-FULL NAME Eugene A. Drewer

(a) RESIDENCE NO. 1117 Sargeant ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year) May 16th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Helper

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Zachary Drewer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr Eugene Drewer (Address) 1117 Sargeant St

15 MAY 9 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/15/ 1922, to 5/6/23, 19

that I last saw h— alive on 5/6/23, 19

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Head Pancreas & metastasis to Liver & Stomach

(duration) Thirty yrs. 5 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of April 1923

Was there an autopsy? No July 1923

What test confirmed diagnosis? Clinical

(Signed) Leonard J. Tenny M. D.

5/7/ 1923 (Address) 910 N. Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL May 9th 1923

20 UNDERTAKER Edw. F. Cowan & Son

ADDRESS 901 Hollins St

N. B.—WRITE PLAINLY. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should bear in mind that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75601

CERTIFICATE OF DEATH.

21 D75601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Marguerite Denk

(a) RESIDENCE NO. 938 Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Apr 28-1923

7 AGE: Years — Months — Days 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Denk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary E Faulstich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John Denk

(Address): 907 E Lafayette Ave

15 Filed ..... 19 .....

MAY 9-1923

ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4 1923 to May 7 1923, that I last saw h[illegible] alive on May 7 1923, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Ulcers Cardiac Dilatation

Pulmonary Edema

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Hebrew Hospital.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Moses Gellman, M. D.

5/7, 1923 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: May 9, 1923

20 UNDERTAKER: John Queen

ADDRESS: 2005 Aisquith

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form — 6-9-19 — H. P. Co. — 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75602
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

46 D75602
REGISTERED NO.

CITY OF BALTIMORE: (No. 1639 E North Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Cecelia Lambert

(a) RESIDENCE. NO. 1639 E. North Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frederick Lambert

6 DATE OF BIRTH (month, day, and year) Aug. 15- 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Fitzpatrick

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Staylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. Shaw.
(Address) 1639 E North Ave.

15 Filed MAY 9 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 8, 1923, that I last saw h[illegible] alive on May 7 1923, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus.
Contributory history of case—
(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Toxaemia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Section made.

(Signed) George Abner Bender, M. D.
5/8, 1923 Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bertz Cemetery	May 11 1923
20 UNDERTAKER John Deemer	ADDRESS 2008 Orleans

mation should be carefully supplied. Age should be given in years, months and days. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75603

CERTIFICATE OF DEATH.

99-001

D75603

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 Aisquith ST., 5 WARD)

2-FULL NAME Rivka Blank

(a) RESIDENCE NO. 109 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 64 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None (Housework)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Morris Pearlstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Blank

(Address): 1133 S. Fourth St. Phila

15 MAY 9 - 1923 ROBERT R. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1923, to May 8th, 1923.

that I last saw her alive on —, 1923

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L Winnis, M. D.

5-9, 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Adath Mt Carmel

DATE OF BURIAL: 5/9 1923

20 UNDERTAKER: L Lerner & Bro

ADDRESS: 127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75604

CERTIFICATE OF DEATH.

100-001

D75604

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Bert ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Virginia Cox

(a) RESIDENCE. No. 1825 Bert ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12.19.21

7 AGE 1 Years 4 Months 18 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Julian Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Barbary Curran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Julian Cox

(Address) 1825 Bert St

15 Filed MAY 9 - 1923 ROBERT R. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5.7. 1923

17

I HEREBY CERTIFY, That I attended deceased from 5.2. 1923, to 5.7. 1923, that I last saw h.r alive on 5.7. 1923, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. J. Denlington, M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	5/9 1923
20 UNDERTAKER	ADDRESS
I. Few McCully	130 E. Fort

Mutilated.

All information should be carefully supplied. Age must be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75605

CERTIFICATE OF DEATH.

X110 D75605

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Muriel Mendelsohn

(a) Residence No. Edgewood, Md. St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 18th 1919

7-AGE. 4 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): New York

PARENTS.

10-NAME OF FATHER: Michael Mendelsohn

11-BIRTHPLACE OF FATHER (city or town) (State or Country): New York

12-MAIDEN NAME OF MOTHER: Anna Holt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14- (Informant): First Cousin

(Address):

15- MAY 9 - 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 8 '23

17- I HEREBY CERTIFY, That I attended deceased from May 4 19 23 to May 8 19 23

that I last saw h. alive on May 7 19 23

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Stricture Oesophagus

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cachexia, Cardiac failure (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Gastrostomy

Did an operation precede death? yes Date of 5-5-23

Was there an autopsy? No

What test confirmed diagnosis? X-Ray & Oesophagoscopy

(Signed) D. Bryson Delavan M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New York City DATE OF BURIAL: 5/9, 19 23

20-UNDERTAKER: Sir & Finlay Infelton ADDRESS: Fayette

should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75606

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5th Ave & 27th St. St.: No WARD)

2-FULL NAME Mary Elizabeth Stever

(a) RESIDENCE. No. 5th Ave & 27th St. St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Sw	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21-1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Edgemere Sp. Point
(State or country)

PARENTS

10 NAME OF FATHER George M. Stever

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mamie Gillmore

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant George M. Stever
(Address) 5th Ave & 27th St.

15 Filed MAY 9 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1923, to May 8th, 1923, that I last saw her alive on May 8th, 1923, and that death occurred, on the date stated above, at 3.55 m.

The CAUSE OF DEATH* was as follows:

Measles -

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb M. Athey, M. D.

19 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	5/9/23 19
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75607

D75607

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Madison Av ST.) 14 WARD)

2-FULL NAME Page Dame Adreon

(a) RESIDENCE. NO. 1721 Madison Av ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Franklin Adreon

6 DATE OF BIRTH (month, day, and year) Mch. 10-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	/	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Childs Hygene 348

(b) General nature of industry, business, or establishment in which employed (or employer) Health Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Dame D.D.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Amelia Hinks

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Geo. W. Dame D.D.
(Address) 1721 Madison Ave.

15 MAY 9 - 1923 ROBERT R. KRAUTER, Registrar
Buried Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6th, 1923, to May 7th, 1923.

that I last saw h er alive on May 7th, 1923.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Heintzy, M. D.

, 19 (Address) 2302 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 10 1923
20 UNDERTAKER	ADDRESS
Chas. E. Franck & Son	Madison Ave

mation should be carefully supplied. Any omission may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75608

129 D75608

D75608

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 N. Fulton Ave. ST., 16 WARD)

2-FULL NAME Thomas F. Landon

(a) RESIDENCE NO. 724 N. Fulton Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Landon

6 DATE OF BIRTH (month, day, and year) Apr. 8" 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired R. R. 078

(b) General nature of industry, business, or establishment in which employed (or employer) Conductor

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Mr. Landon

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md.

14 Informant Mr. Thomas W. Landon
(Address) Clendenin, W. Va.

15 MAY 9-1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7" 1923

17 I HEREBY CERTIFY, That I attended deceased from March 6", 1923, to May 7, 1923, that I last saw him alive on May 6", 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Interstecial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Herbert E. Gephart, M. D.

5/8/1923 (Address) 3048 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	May 9" 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

IMPORTANT: This information should be carefully supplied. AGE should be stated EXACTLY. Statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75609

CERTIFICATE OF DEATH.

REGISTERED NO. 13

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3711 Elm Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn L. Sherman

(a) RESIDENCE NO. 3711 Elm Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Selwin Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cora Deamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Sullivan Sherman
(Address) 3711 Elm ave

15 Filed MAY 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 8, 1923.

that I last saw her alive on May 7, 1923.

and that death occurred, on the date stated above, at 7 A.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Davies, M. D.

(Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Carroll Co | DATE OF BURIAL May 10 23

20 UNDERTAKER Chenoweth & Son | ADDRESS Chestnut ave

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

Quinn

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

D75610

D75610

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 W. 27th ST., 17 WARD)

2-FULL NAME James F. Quinn

(a) RESIDENCE NO. 101 W. 27th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 14, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Martha Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Mary A. Shields 101 W. 27th St

15 MAY 9-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 8, 1923, that I last saw h— alive on May 8, 1923, and that death occurred, on the date stated above, at 4:30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) hrs. min.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. months days

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. A. Thelander M. D.

May, 19 23 (Address) 112 W. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cemetery Md.	May 11 1923
Mt. Pony Green Md.	ADDRESS

20 UNDERTAKER George J. Smith

I. Burial permit should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

Spicer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75611

CERTIFICATE OF DEATH.

129 D75611

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women's Home ST., 19 WARD)

2-FULL NAME Annie E Spicer

(a) RESIDENCE NO. 1400 W Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William Spicer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Frances Terrell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Ella Jones
(Address) 1400 W Lexington

15 MAY 9-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1920, to May 8, 1923,
that I last saw h alive on May 5, 1923
and that death occurred, on the date stated above, at 2-20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? J Norwood

(Signed) J Norwood, M. D.

May 9, 1923 (Address) 939 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 10 1923
20 UNDERTAKER	ADDRESS
George J Smith	Hollins 532

N. B.—WHITE BLANKS ONLY should be used. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Blks.

D75612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 15 WARD).

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Baugh.

(a) RESIDENCE NO. 3008 Clifton Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 11-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	21	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER E. V. Baugh.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine M. Croft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wis.

14 Informant E. V. Baugh

(Address) 3008 Clifton Ave

15 Filed MAY 9-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/6, 1923, to 5/7, 1923, that I last saw h[illegible] alive on 5/7, 1923, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 17 mos ..... ds.

CONTRIBUTORY (Secondary) Lung Abscess

(duration) yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 5/7/23

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Co findings

(Signed) Iron Sheldon, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL May 10, 1923

UNDERTAKER Wm Pickrell & Sons — ADDRESS Norfolk Va

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec. 1-1921 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75613

CERTIFICATE OF DEATH.

90 D75613

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3300 Walbrook Ave. ST. 15 WARD)

2-FULL NAME Mary Frances Diggs.

(a) RESIDENCE NO. 3300 Walbrook Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Samuel L. Diggs.

6 DATE OF BIRTH (month, day, and year) March 5-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury Maryland.

PARENTS

10 NAME OF FATHER William Thorington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Pedrum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Rose M. Rock

(Address) Salisbury Md.

15 MAY 9-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to May 7, 1923,

that I last saw h e alive on May 7, 1923,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 2 ds. (21)

CONTRIBUTORY (Secondary) Pott's Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No. Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) John A. Evans, M. D.

, 19 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salisbury Md.	5/9/23
20 UNDERTAKER	ADDRESS
H. E. Hughes & Co.	Salisbury Md.

Information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D75614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75614

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N. Curley ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa L. Stocker

(a) RESIDENCE NO. 513 N. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 3 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Casper Stocker

6 DATE OF BIRTH (month, day, and year): Jan 15 70

7 AGE — Years: 53 — Months: 3 — Days: 11 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Carl Hunger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine May

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Casper Stocker

(Address): 513 N. Curley St.

15 [illegible] 14, 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3 - 1923, to May 6, 1923

that I last saw her alive on May 6, 1923

and that death occurred, on the date stated above, at 4-10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broken Compensation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? by Exam

(Signed) Geo C. H. Blades, M. D.

(Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: H. Mathews Cem. — DATE OF BURIAL: 5/9 1923

20 UNDERTAKER: Philip Henrig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should mation should be carefully classified. Exact statement of OCCUPA- that it may be properly CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75615

100 001

CERTIFICATE OF DEATH.

D75615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) ST., 6 WARD)

2-FULL NAME Isaac Deitchman

(a) RESIDENCE NO. 20 N. Collington ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie D. Deitchman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

080

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jack Lewis

(Address) 1439 E Baltimore

15 MAY 9-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1923, to May 8, 1923,

that I last saw him alive on May 8, 1923

and that death occurred, on the date stated above, at 11.40 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Subacut Pactrial Endocarditis.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? none

(Signed) Isidore S. Frey, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	May 9 1923

20 UNDERTAKER ADDRESS

Jack Lewis 1439 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms; so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D75616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D75616

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Fairview Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Carrie Hall

(Residence in Baltimore: No. 920 Argyle Ave ST.: (yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... April ....., 1897
(Month) (Day) (Year)

7-AGE. 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Asbury Ridcout

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Attila Wells

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Ridcout

(Address) 910 Myrtle Ave

15- Filed MAY 9-1923, 191.. ROBERT M. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Peritonitis

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Abortion

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) J. J. Heuisler, M. D. (Coroner.)

May 9, 1923 (Address) 2811 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	May 9, 1923
20-UNDERTAKER	ADDRESS
John H. Todd	142 W. Hill St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75617 HEALTH DEPARTMENT—CITY OF BALTIMORE D75617

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3807 Maiden Montebello Park ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Brickenberger

(a) RESIDENCE. No. 3807 Maiden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mr 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Levi Brickenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rinnel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Lurline Brown (Address) 3807 Maiden

15 MAY 9 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April xx, 1923, to May 6, 1923, that I last saw h.d alive on May 6, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronco Pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F Lennau, M. D.

5/7 1923 (Address) 718 N Fallsway Bltm

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 9 1923
20 UNDERTAKER W. M. Routson	ADDRESS 2238 N Monte

mation should be carefully supplied. Any information that may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75618 HEALTH DEPARTMENT—CITY OF BALTIMORE D75618

CERTIFICATE OF DEATH.

REGISTERED NO. 114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Belfast Av Nr. Maple Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Angelo Mueller

(a) RESIDENCE NO. 13 Belfast Ave Nr Maple Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 7/10/1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen Klendan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George Mueller

(Address) 13 Belfast Ave

15 FILED MAY 9 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1923, to May 7, 1923.

that I last saw h[illegible] alive on May 6, 1923,

and that death occurred, on the date stated above, at 4.55 A. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible], M. D.

5/7, 1923 (Address) Mayfield, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 5/9/23

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75619

CERTIFICATE OF DEATH.

164 D75619

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1122 Leadenhall ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob H. Vickers

(a) RESIDENCE NO. #1122 Leadenhall ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Kate Vickers.

6 DATE OF BIRTH (month, day, and year) September, 20, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	84,	7,	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired U. S. Army

(b) General nature of industry, business, or establishment in which employed (or employer) Veteran.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

14 Informant Carrie Gentry, (Address) #1122 Leadenhall St.

15 MAY 9-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2 1923 to May 6th 1923.

that I last saw him alive on May 6th 1923,

that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B. Kolb, M. D.

(Address) 1203 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	May, 10, 1923.

20 UNDERTAKER A. Howard Evans, ADDRESS 1428 S. Charles St.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16 D75620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... St., 7 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

2-FULL NAME Charles Walter Moore

(a) RESIDENCE NO. 407 "C" Street, South Charleston, W. Va.

(Usual place of abode) St. Ward (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Moore

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer for Do

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Store

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Samuel Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Virginia

12 MAIDEN NAME OF MOTHER Armilda Bradshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Virginia

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 MAY 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to May 8, 1923, that I last saw him alive on May 8, 1923, and that death occurred, on the date stated above, at 9.45 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Charleston W. Va.

Did an operation precede death? No, Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Blood sugar etc.

(Signed) E Carter Andrus, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charleston, W. Va	May 9 1923
20 UNDERTAKER	**ADDRESS**
Henry W. Maas & Son	804 N. Calvert St

W. Va. Penn. R.R. Mrs. Charles W. Moore, Escort

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—1-10-21—MAT—1500 Blks.

D75621 **HEALTH DEPARTMENT---CITY OF BALTIMORE** 38 D75621

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ..... (St.) Municipal Tuberculosis Hospital (Ward) 17

REGISTERED No: .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Johnson

(a) RESIDENCE No. 1008 Pennsylvania ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Johnson

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 670

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) North Carolina

PARENTS

10 NAME OF FATHER Ira Pegg

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ella Jones

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) North Carolina

14 Informant ..... (Address) Hospital Records M.T.H.

15 Filed MAY 9-1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to May 7, 1923, that I last saw her alive on May 7, 1923, and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Aneurysm

(duration) 1 ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) Unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Francis L. Sadaglissea M. D.

5-7-23. 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-9-1923
20 UNDERTAKER Frank Ferber	ADDRESS 916 Penna Ave

mation should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-21-21 E.R.P.S. 400 Blks.

D75622 HEALTH DEPARTMENT—CITY OF BALTIMORE

D75622

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1664 Darley ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W Atwell

(a) Residence No. 1664 Darley ave St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 76 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Katrine Atwell

6-DATE OF BIRTH (month, day and year) June 8-1847

7-AGE. 76 yrs. 1 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Benjamin Atwell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Kat Rowe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs Lady Smith

(Address) 1664 Darley ave

15- Filed MAY 9 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 8-1923

17- I HEREBY CERTIFY, That I attended deceased from May 7 1923 to May 8 1923 that I last saw him alive on May 8 1923 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma Ventriculi (Cancer of the Stomach).

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination.

(Signed) David J. Mostitz, M. D

, 19 (Address) 3720 Ambulance Tunnel

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oakdale cemetery — DATE OF BURIAL. May 11 1923

20-UNDERTAKER. W J Hartley — ADDRESS 815 N Washington

Should be carefully examined, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-21-21—E.B.R.S.—400 Blks.

D75623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75623

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital, St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Augusta Skates

(a) Residence No. 2514 Frances St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 1854

6-DATE OF BIRTH (month, day and year) Aug 10th 1854

7-AGE.	If LESS than 1 day,
68 yrs. 8 mos. 29 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ppd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John B. Skates

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, Elizabeth Marks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed. MAY 9-1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 23, 19 23 to May 8 19 23

that I last saw her alive on May 8 19 23,

and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

chronic myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. G. McKay, M. D

5-9-, 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	5/11 1923
20-UNDERTAKER. Wm Cook	ADDRESS 502 E Monument

Should be carefully answered so that it may be properly classified. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75624

CERTIFICATE OF DEATH.

11-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Ettinj ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Finney

(a) RESIDENCE NO. 1909 Ettinj ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work meat cutter 013

(b) General nature of industry, business, or establishment in which employed (or employer) Swift & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Accomac Co., (State or country) Va.

PARENTS

10 NAME OF FATHER James Finney

11 BIRTHPLACE OF FATHER (city or town) Accomac Co., (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Kellam

13 BIRTHPLACE OF MOTHER (city or town) Accomac Co., (State or country) Va.

14 Informant Dora Montague (Address) 1909 Ettinj St.

15 MAY 9-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4- ,1923, to to May 7- ,1923; that I last saw him alive on May 6 - ,1923; and that death occurred, on the date stated above, at 8:40 a. m.

The CAUSE OF DEATH* was as follows:

Influenzal Peritonitis

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Influenzal Pleurisy.

(duration) — yrs. 2 mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

5-8, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Accomac Co Va	5-10 1923
20 UNDERTAKER George H Holland	ADDRESS 1631 Pennsylvania Ave

mation should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D75625

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 N. Mount ST., 15 WARD)

2-FULL NAME Lucy Coleman

(a) RESIDENCE NO. 1320 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jos Coleman

6 DATE OF BIRTH (month, day, and year) Jan 9 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46		4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Jos Coleman 1320 Mount st

15 MAY 9-1923 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8- 1923

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1923, to May 8, 1923, that I last saw her alive on May 8, 1923, and that death occurred, on the date stated above, at 9.40 a1 m.

The CAUSE OF DEATH* was as follows:

Cancer of Cervix of Womb

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Mullen, M. D.

5/8, 1923 (Address) 1230 St. Paul ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 11 1923
20 UNDERTAKER Geo H Holland	ADDRESS 1631 D4 ave

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75626

D75626

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Baby Isaac Wetzel

(a) RESIDENCE NO. University Hospital ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7, 1923

7 AGE — Years — Months — Days — If LESS than 1 day: 3 hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Otto Wetzel

11 BIRTHPLACE OF FATHER (city or town) Bladensburg Md
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Carrick

13 BIRTHPLACE OF MOTHER (city or town) Aberdeen
(State or country) Maryland

14 Informant Mother
(Address) JOHNS HOPKINS HOSPITAL

15 May 9-1923 Robert P. Harrison, ... 19 .....
Burial Permit Clerk. Registrar

0.30.5

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to May 7, 1923,
that I last saw h.. alive on May 7, 1923,
and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth
Ve Weak

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) I. Norwood Wilson M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER Commissioner Health, MAY 9 1923

...

mation should be carefully supplied. Exact statement of OC...
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

D75627

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75627

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Elizabeth Walker

(a) Residence No.... 933 Clifford St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Carter Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Julia Mills

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed MAY 10 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 1 19 23 to May 6 1923, that I last saw h.er alive on May 6 1923, and that death occurred, on the date stated above, at 2:35 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

leading to heart failure

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Mackey M. D

5-7-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn St	May 10, 1923
20-UNDERTAKER.	ADDRESS
S. W. Brumgardner Son	108 W Monroe St

Should be carefully read, so that it may be properly classified. Except statement of OCCUPATION is very important. Fill in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

D75628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7400 D75628

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Harford ave ST., 9 WARD)

2-FULL NAME Geo T. Flemming

(a) RESIDENCE NO. 1611 Harford ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Flemming

6 DATE OF BIRTH (month, day, and year) July 28-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	Four		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter 06

(b) General nature of industry, business, or establishment in which employed (or employer) Carrier

(c) Name of employer U. S. Govmt. Baltimore.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry. Flemming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine O'Malley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. A. Flemming

(Address) 1611 Harford Ave.

15 Filed MAY 10 1923 16 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 27 1923 to May 7 1923.

that I last saw h alive on May 7 1923,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Thomas, M. D.

May 9 1923 (Address) 1228 N. Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL 5/11 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be exactly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAY—1500 Blks.

D75629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135

D75629

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1504 Olive ST., 8 WARD)

2-FULL NAME Patrick C. O Donnell.

(a) RESIDENCE NO. 1504 E Olive ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary. O Donnell.

6 DATE OF BIRTH (month, day, and year) April 15-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Norfolk.

PARENTS

10 NAME OF FATHER John O Donnell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Va.

12 MAIDEN NAME OF MOTHER Mary Allard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk.

14 Informant Mary O Donnell (Address) 1504 E. Olive

15 MAY 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3 . 1923 . to May 7 . 1923 .

that I last saw him alive on May 7 . 1923 ,

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Uramic Coma

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cystitis - Prostatic hypertrophy

(duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm F. Watson, M. D.

May 9. 1923 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	5/10 1923
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Hanford Ave

mation should be carefully supplied. AGE should be always properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75630

CERTIFICATE OF DEATH.

41-002 D75630

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D75630
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Eastern Ave ST., 3 WARD)

2-FULL NAME. Laura McCain

(a) RESIDENCE NO. 1401 Eastern Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm McCain

6 DATE OF BIRTH (month, day, and year) 6/15/1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS
10 NAME OF FATHER: John Miller
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm McCain
(Address): 1401 Eastern Ave

15 Filed MAY 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to May 7, 1923,
that I last saw her alive on May 7, 1923,
and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:
Heart Failure due
to Arteria-Sclerosis.
(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Jack L. Valentine M. D.
May 9, 1923 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL 5/10 1923

20 UNDERTAKER: George J Ruth — ADDRESS 1735 Harford Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75631

CERTIFICATE OF DEATH.

101-001 ✓

D75631

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2240 Cambridge ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Kissling

(a) RESIDENCE No. 2240 Cambridge ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknow

14 Informant Julius Kissling

(Address) 2240 Cambridge St

15 MAY 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1923

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1923, to May 9, 1923.

that I last saw him alive on May 8, 1923

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 7 mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. D Greer, M. D.

5/15/1923 (Address) 408 S. Pat Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
I St German	May 12 1923
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2060 Eastern Ave

information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75632 HEALTH DEPARTMENT—CITY OF BALTIMORE D75632

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Druid Hill Ave ST.) 14 WARD)

REGISTERED NO. 1486

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Smith—

(a) RESIDENCE NO. 2204 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Joseph T. Smith—

6 DATE OF BIRTH (month, day, and year) Aug 24 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Rosa Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph T. Smith— (Address) 2204 Druid Hill Ave

15 Filed May 10 1923 19

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 4th, 1923, to May 7th, 1923, that I last saw her alive on May 6th, 1923, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Anemia — Acute Nephritis

(duration) yrs. 3 mos. 1 da.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) A. Lee Ellis, M. D.

578, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leberry DATE OF BURIAL May 10 1923

20 UNDERTAKER P. C. Gross ADDRESS 405 McElderry

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75632

CERTIFICATE OF DEATH.

41 D75633

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Pauls Gen'l Hosp ST., 7 WARD)

2-FULL NAME Mrs Emma Walter

(a) RESIDENCE NO. 703 N Collington Ave: ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William Walter Mulvaney

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Shubeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mary Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant William Walter

(Address) 703 N Collington Ave

15 Filed MAY 10 1923, ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17

I HEREBY CERTIFY, That I attended deceased from May 5 1923, to May 7 1923,

that I last saw her alive on May 7 1923,

and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

No Inquest necessary
Otto M Reinhardt MD
Coroner

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Connor, M. D.

, 19 (Address) Saint Pauls Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill — DATE OF BURIAL May 10 1923

20 UNDERTAKER Frank Enochs — ADDRESS 1806 Eastern Ave

mation should be carefully supplied. AGE should be stated in such terms that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Streptococcus Infection

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75634 CERTIFICATE OF DEATH. D75634

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pleby's Dawson

(a) RESIDENCE NO. White's Farm, Mt. Washington, R. 9.
(Usual place of abode) ST. WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 17, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Harry Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Josphie Dawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL (Address) ROBERT H. CHAUTEN,

15 Filed MAY 10 1923 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1. 1923. to May 9. 1923. that I last saw him alive on May 9. 1923 and that death occurred, on the date stated above, at 1.00 A m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X

(Signed) A. A. Mesch, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Hartford Rd

DATE OF BURIAL May 10 1923

20 UNDERTAKER Herman Cook

ADDRESS Sol E Nork

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY in all cases. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. It is very important.

Spec.—1-10-21—M&T—1500 Bks.

D75635 HEALTH DEPARTMENT—CITY OF BALTIMORE 58-09 D75635

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 S. Mount ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Graham

(a) RESIDENCE NO. 22 S. Mount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John Graham

6 DATE OF BIRTH (month, day, and year) March 15-1830

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	93	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Annie Graham

(Address) 4 N. Fulton Ave

15 MAY 10 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1923

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1923, to May 5, 1923, that I last saw h alive on May 5, 1923, and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Senility Enemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Apoplectic paralysis

(Signed) E. L. Simmons Lin, M. D.

5-9, 1923 (Address) 722 S. Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 11 1923.

20 UNDERTAKER Elmer A. Conklin

ADDRESS 924 E Eager St

...mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1099 Bks.

D75636 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 001 D75636

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Washington Blvd ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Riehl

(a) RESIDENCE. No. 805 Washington Blvd WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Divorced

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Lena Riehl

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Binder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Riehl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cristiana Karl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Riehl Jr. (Address) 911 S. Paca St.

15 BY MAY 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-8- 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-6- 1923, to 5-8- 1923, that I last saw h[illegible] alive on 5-8- 1923, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Raphael Drain, M. D.

, 19 (Address) 1137 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	May 12, 1923.
20 UNDERTAKER Chas. W. Dill.	ADDRESS 3109 Fredk. Ave.

matter should be entered, supplied, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75637

CERTIFICATE OF DEATH.

45 D75637

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N Carlton ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christine Bryan

(a) RESIDENCE NO. 515 N Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	C	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Ot

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wm Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Dickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sister Bryan

(Address) 515 N Carlton St

15 MAY 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1923, to May 8, 1923,

that I last saw h alive on May 7, 1923

and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cancer Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. 3 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

May 9 1923 (Address) 709 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5-11-1923

20 UNDERTAKER David Turner

ADDRESS 911 Eutaw

AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. EXACTLY as it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D75638 HEALTH DEPARTMENT—CITY OF BALTIMORE D75638

CERTIFICATE OF DEATH.

5 183

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE (No. Pronounced dead at St. Joseph Hosp. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Bowie

(Residence in Baltimore: No. 1116 Orleans St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
male	col.	Single

6-DATE OF BIRTH, ... Jan. 6/1907 ....., 1 .....
(Month) (Day) (Year)

7-AGE, 16 yrs. 4 mos. 2 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... no vocation.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... odd jobs

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Walter Bowie

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Lousia Curry

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Walter Bowie.....

(Address)..... 1116 Orleans St.

15-
Filed ....., 191... ROBERT R. KRAUTER.....
Registrar.
Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May 8/23 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ...autopsy.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

...Pistol shot thru heart - said to be accidental - Inquest to be held May 10/23 at 8.30 P.M. (shot fired by Geo. W. Midgett)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

5/9/23 191... (Address) ...508 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem -	5-12, 1923
20-UNDERTAKER Daniel Eaton	ADDRESS 916 E. Pratt

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75639

CERTIFICATE OF DEATH.

10 D75639

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Hare ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Hammen

(a) RESIDENCE NO. 124 N. Hare ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20/18

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Harry Hammen

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Alice V. Hess

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Harry Hammen

(Address) 124 N. Hare

15 MAY 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1923, to May 9, 1923, that I last saw him alive on May 8, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Culture

(Signed) Jno Clinton Blades, M. D.

19 (Address) 1436 Bray.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	May 10 1923
20 UNDERTAKER Philip Hennig	ADDRESS 9016 Orleans

...mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. ...TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75640 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75640

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 412 S. Eden St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rocco Spina

(a) Residence No. 412 S Eden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 10 1922

7-AGE.	If LESS than 1 day.
..yrs. 7 mos. ..ds.	..hrs. or..min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Rocco Spina

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mary Kaucci

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant) Rocco Spina

(Address) 412 S Eden

15- Filed MAY 10 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 8-1923

17- I HEREBY CERTIFY, That I attended deceased from May 1 1923 to May 8 1923, that I last saw h[illegible] alive on May 8 1923, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D

May 10, 1923 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer	May ..19..
20-UNDERTAKER.	**ADDRESS**
Wendell Bufalini	37 S [illegible]

In order to be correctly classified, Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 lbs.

D75641 ✓ D75641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75641

CERTIFICATE OF DEATH.

John Harries 101-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 630 Eastern ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Harris Jr

(Residence in Baltimore: No. 630 Eastern St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Black	

6-DATE OF BIRTH, 25 Dec (Month) (Day), 1922 (Year)

7-AGE, ...yrs. 4 mos. ....da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE, (State or Country), 630 Eastern St

PARENTS.

10-NAME OF FATHER, John Harries

11-BIRTHPLACE OF FATHER (State or Country), Richmond Va

12-MAIDEN NAME OF MOTHER Sodnia Garrett

13-BIRTHPLACE OF MOTHER (State or Country), Arnal Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Harris Father

(Address) 630 Eastern Street

15- ROBERT R. KRAUTER,

Filed ..... 191.. Registrar.

MAY 12 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 5 1923, to May 8 1923 that I saw h[illegible] alive on May 8 1923 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. ....mos. 5 da.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) ....yrs. ....mos. 2 da.

(Signed) C. N. Timan M. D.

May 9, 1923 (Address) 712 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Ft Auburn Cemetery | DATE OF BURIAL, May 16, 1923

20-UNDERTAKER Chas Gerhold | ADDRESS [illegible]

N. B. Each item of information must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75642

CERTIFICATE OF DEATH.

D75642

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 15 WARD)

2-FULL NAME Joseph Hurley

(a) RESIDENCE NO. 1633 Presbury st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Hurley

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Toney

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 MAY 10 1923 ROBERT E. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1923, to May 8, 1923, that I last saw him alive on May 8, 1923, and that death occurred, on the date stated above, at 10. a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) F. L. Badeglucco M. D.

5-8-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Saint Peters Cemetery	May 11. 1923
20 UNDERTAKER	ADDRESS
Wm Robert & Elliott	Oakland Md

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75643

CERTIFICATE OF DEATH.

49 D75643

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2747 Mosher ST., 16 WARD)

2-FULL NAME Henry A. Albert

(a) RESIDENCE NO. 2747 Mosher St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Etta P. Correll

6 DATE OF BIRTH (month, day, and year) Jan 20 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	3	19	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Beverage

(b) General nature of industry, business, or establishment in which employed (or employer) Inspector

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Augustus Albert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Hatch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Amelia Correll
(Address) 2747 Mosher St.

15 Filed MAY 10 1923 19 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 8 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-6 - 1921 to 5 - 8 1923.

that I last saw him alive on May 7 - 1923,

and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Uremia —

(duration) ... yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma, Bladder - infiltrating type (duration) about 8 months yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis? Cystoscopic Examination

(Signed) Austin L. Wood, M. D.

5-10-1923 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL May 11 1923

20 UNDERTAKER C. B. Wiseley ADDRESS 2156 Fred'k Ave

mation should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 2 | D75644

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

2-FULL NAME Thomas Kane

(a) RESIDENCE NO. Non-resident. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Daniel Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Maggie Teifus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address): M.T.H.

MAY 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk

File 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to May 8, 1923,

that I last saw him alive on May 8, 1923,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dadaglucci M. D.

5-8-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md.	5-10 1923
20 UNDERTAKER: E B Harle 115 E West St	ADDRESS

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D75645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1114 D75645

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 Mc Cullohs ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. H. Lewis

(Residence in Baltimore: No. 1114 McCulloh St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	col.	married

6-DATE OF BIRTH, about 1844 (Month) (Day) 1 (Year)

7-AGE, 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Tobacco

9-BIRTHPLACE, (State or Country), Africa

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Alabama

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Lewis

(Address) 1114 McCulloh

15-

FILED MAY 10 1923 191 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a. Cirrhosis of Liver

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Hewson M. D. (Coroner.)

, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	May 10 1923
20-UNDERTAKER	ADDRESS
Wm A Bishop & Son	1107 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If child is under one year, or person under one day, the fraction of a year or day may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75646 CERTIFICATE OF DEATH. 18 129 D75646

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucas Miller

(a) Residence No. 1213 E. Lexington St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1857

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Missouri

PARENTS.

10-NAME OF FATHER, Lou Miller

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Missouri

12-MAIDEN NAME OF MOTHER, Violet Riley

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Missouri

14- (Informant) Municipal Hospital Records

(Address) UNIV

15- MAY 10 1923 192. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

0366

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 5 19 23 to May 7 19 23

that I last saw him alive on May 6 19 23

and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 1 yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) Heart Failure

(Duration) ..... yrs. 6 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) O. A. McCay M. D

5-7-19 23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND DATE OF BURIAL. ....., 19....

20-UNDERTAKER. Commissioner Health ADDRESS MAY 10 1923

Should be filled out in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75647 ✓ 101-001 D75647

D75647

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 16 WARD)

2-FULL NAME Mrs. Anna Scheck

(a) RESIDENCE NO. 203 S. Clinton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Scheck

6 DATE OF BIRTH (month, day, and year) July 19-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	9	20	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Hellert

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant John Scheck (Address) 203 S. Clinton St.

15 Filed Robert P. Harrison, Registrar

MAY 10 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1923

17 I HEREBY CERTIFY, That I attended deceased from May 8 ..... 1923, to May 9 ..... 1923, that I last saw her alive on May 9 ..... 1923, and that death occurred, on the date stated above, at 6.30 P. m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Secondary Anemia due to bleeding hemorrhoids

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? o

(Signed) M. Heller Resident, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cat Lawn Cem	May 12 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75648
16344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X49 D75648

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W. Fitzpatrick

(a) RESIDENCE NO. 718 Boyer St., Mt. Airy, Philadelphia, Pa.
(Usual place of abode) ST. WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Mattie
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James F. Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Gault

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Robert F. Harris, Record

Filed ..... 19 ..... Burial Permit Clerk ..... Registrar

Via American Railway Express

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1923, to May 9, 1923, that I last saw him alive on May 9, 1923, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of the Prostate

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Rectal examination

(Signed) Eugene L. Shaw, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia, Pa.	5/10, 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

10 1923

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75649 HEALTH DEPARTMENT—CITY OF BALTIMORE D75649

99-002

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2814 N. Calvert St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joanna E. Norris

(a) Residence No. 2814 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 24 1845

7-AGE, 77 yrs. 5 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Frederick Co. Md

PARENTS.

10-NAME OF FATHER. Nicholas Norris

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Frederick Co. Md

12-MAIDEN NAME OF MOTHER. Mary Ann McKinsley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Samuel E. Norris

(Address) 2814 N. Calvert St.

15- 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 10 - 1923

17- I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 10, 1923.

that I last saw h~~e~~ alive on May 9, 1923

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. B. Norment M. D.

5.10, 1923 (Address) 334 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery

DATE OF BURIAL. May 14 1923

UNDERTAKER. John O. Mitchell

ADDRESS 201 W Fayette St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Drumgoole)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75650 ✓ D75650

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 W Mosher ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw. L. W. Drumgoole

(a) RESIDENCE NO. 1330 W Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Allen Drumgoole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Nannie Drumgoole

(Address) 1330 W Mosher St

15 Filed ....., 19.... Robert P. Garrison Registrar

10 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to May 9, 1923, that I last saw h.. alive on May 8, 1923, and that death occurred, on the date stated above, at 4 1 m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonal Nephritis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Horwood, M. D.

May 9 '23 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn, Balto | DATE OF BURIAL 5/11th 1923

20 UNDERTAKER Jas. W. Skinner | ADDRESS 1635 E. Mad st

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75651

CERTIFICATE OF DEATH.

REGISTERED NO. D75651

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dize

(a) RESIDENCE NO. Harborton, Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manis Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Robt H. Dize

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Records (Address)

MAY 11 1923

ROBERT A. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/8/ 1923, to 5/10 1923

that I last saw him alive on 5/10 1923

and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ouhide

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) Thos Riordon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harborton Va	May 11 1923

20 UNDERTAKER Harry H. Witzke, ADDRESS 1531 W. Lombard St

should be carefully supplied. Age must be given in YEARS, MONTHS and DAYS if under one year. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Wehrman

(a) RESIDENCE NO. 348 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7th 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	16	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Henry A Wehrmann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Gertrude Rebhmann

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs H Wehrmann
(Address) 348 E Woodyear st

15 MAY 11 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1923. to May 9, 1923.

that I last saw her alive on May 9, 1923.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John J. Kiger M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 12, 1923

20 UNDERTAKER Chas Fields — ADDRESS 1200 N Gorsuch

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may TION is very important See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D75653

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3503 Penna ave ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Kirsner

(a) RESIDENCE No 3503 Penna ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bessie Kirsner

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	53	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Jacob Kirsner

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Bernie Barr

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Josh Levin
(Address) 1439 E Baltimore

15 MAY 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1923

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to May 9, 1923, that I last saw h[illegible] alive on May 9, 1923, and that death occurred, on the date stated above, at 8450 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris Goldman, M. D.

5/11, 1923 (Address) 1512 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Penna Avenue Cem

DATE OF BURIAL: May 11 1923

20 UNDERTAKER Jacob Levin

ADDRESS 1439 E Balto

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Potee

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75654

CERTIFICATE OF DEATH.

31

D75654

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1705 Edmondson Ave. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Potee

(a) Residence No. 1705 Edmondson Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 6, 1883.

7-AGE. 39 11 2.
.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Potee

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary A Kernan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant) Mrs Jane Potee

(Address) 1705 Edmondson Ave

15-Filed MAY 11 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 8, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 8, 1923 to May 8, 1923

that I last saw h alive on 1923,

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. mos. ds

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Cockeland M. D.

5/10, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem

DATE OF BURIAL. 5/11/23

20-UNDERTAKER. Ed C Farley Fulton

ADDRESS Fayette

Be classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Pasco

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 1901 D75655

CERTIFICATE OF DEATH.

D75655

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1848 W. Mulberry ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Pasco.

(a) RESIDENCE. NO. 1848 W Mulberry ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Alice V. Pasco

6 DATE OF BIRTH (month, day, and year) July 9 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clk

(b) General nature of industry, business, or establishment in which employed (or employer) Freight

(c) Name of employer Old Bay Line

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Frederick Pasco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Elizh A Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Charles Pasco (Address) 1848 Mulberry St.

15 MAY 11 1923 ROBERT R. KRAUSE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2 1923, to May 8th 1923, that I last saw h.. alive on May 8th 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Hypostatic pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) Evan Allen M. D.

(Address) 1 W Mary Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 12 1923

20 UNDERTAKER ADDRESS

Jno J Dorsey & Son 901 Hollins Ave

BEFORE signing, be certain that every question has been answered. Exact statement of OCCUPATION may be properly classified. Any unusual abbreviation may be used, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75656

CERTIFICATE OF DEATH.

90 D75656

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST. 120 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frieda Shalin

(a) RESIDENCE NO. 2030 Eagle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 28 yrs. ... mos. ... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chimie Shalin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore St

15 MAY 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1923, to May 11, 1923, that I last saw her alive on May 11, 1923, and that death occurred, on the date stated above, at 2:35 Am.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isidore J. Fury M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rest Rd	May 11 1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balt

Spec.—1-10-21—M&T—1500 Blks.

D75657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118 D75657

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sauk Falls Sanitarium ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Vernon E. Miller

(a) RESIDENCE NO. 1737 Clarkson ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) July, 17, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
		9.	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Edgar Miller.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Witzel.

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Edgar Miller. (Address) 1737 Clarkson St.

15 MAY 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to May 10, 1923, that I last saw him alive on May 10, 1923, and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation -

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Intussusception

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Yes Date of May 10/23

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John A. Cannon, M. D.

(Address) Sauk Falls Sanitarium

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery.	May, 12, 1923.
20 UNDERTAKER	ADDRESS
A. Howard Evans #1428 S.	Charles ST.

mation should be carefully supplied. Any information which may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75658

CERTIFICATE OF DEATH.

74-001 D75658

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1318 Mosher ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Elizabeth Clark

(a) RESIDENCE No. 1318 Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clifford C. Clark

6 DATE OF BIRTH (month, day, and year) Apr 7-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Beacon Falls Conn.
(State or country)

PARENTS

10 NAME OF FATHER Wm S. Whiting

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Haven Conn.

12 MAIDEN NAME OF MOTHER Susan Gray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Reading Pa

14 Informant Clifford C. Clark
(Address) 1318 Mosher St

Filed MAY 11 1923, 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/ 1923

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1923, to May 8, 1923.

that I last saw her alive on May 8, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Robert C Blake, M. D.

, 19 (Address) 1014 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetary	May 11 1923
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	North Ave

Spec.—1-10-21—M&T—1500 Bks.

D75659. HEALTH DEPARTMENT—CITY OF BALTIMORE D75659

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Walbrook Ave ST. 15 WARD) 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilton Crendorff Rosenberger

(a) RESIDENCE No. 2016 Walbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Esther E. Rosenberger

6 DATE OF BIRTH (month, day, and year) Nov 10, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wood & Wire Screen Co

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER James A Rosenberger

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Ella Crendorff

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Mrs. Harry Rosenberger

(Address) 1218 W Lafayette Ave.

15 MAY 11 1923 Filed, ROBERT P. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1923

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1923, to May 9th 1923,

that I last saw him alive on May 9th, 1923,

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) L. Pursch, M. D.

(Address) 232 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 12, 1923
20 UNDERTAKER	ADDRESS
Wm Fickus Sons	North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Abbreviations may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75660

D75660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Hanover ST.: 23 WARD)

2-FULL NAME Michael J. Hegarty

(a) RESIDENCE. NO. 1315 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/4/07

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholar

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Hegarty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Noon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant Mrs. Mary Hegarty

(Address) 1315 Hanover St.

15 Filed MAY 11 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7-23. 19

17

I HEREBY CERTIFY, That I attended deceased from 5.5.23. 19 , to 5.7.23 , 19

that I last saw h[illegible] alive on 5.7.23. 19

and that death occurred, on the date stated above, at 1.43P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

acute Cardiac Dilatation

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) J. Edward Norris, M. D.

5.7.23.19 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	5/11 19
20 UNDERTAKER	ADDRESS
E. Staley Sons	131 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D75661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75661

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat St.: 28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie P. Fahey

(a) RESIDENCE. No. Mt Hope Retreat St. 28th Ward. Grafton W. Va.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? 70 ? 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a ~~If married, widowed, or divorced~~ (or) WIFE of Mr Fahey -

6 DATE OF BIRTH (month, day, and year) Febrvt 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Grafton W. Va

PARENTS

10 NAME OF FATHER Patrick Carney

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath - Lacey.

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland -

14 Informant Reuds Mt Hope (Address) Baltimore

MAY 11 1923 Filed 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 20th 1916 to May 10 1923, that I last saw her alive on May 10 1923, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis - with Cardiac - Valvular - Complication

Abt (duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -

Abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Grafton W. Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grafton - W. Va.	May 11 1923
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

Frank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Millicent R Tall

D75662 HEALTH DEPARTMENT—CITY OF BALTIMORE D75662

CERTIFICATE OF DEATH.

57

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3712 Maine Av. Montebello Park 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Millicent Naomi Tall

(Residence in Baltimore: No. 3712 Maine av Montebello Park St.; 60 yrs., 9 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Aug (Month) 7 (Day) 1864 (Year)

7-AGE. 60 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer) Home - wife

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John T. Davis

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Millicent Naomi Hamsley

13-BIRTHPLACE OF MOTHER, (State or Country). Talbot Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry R Tall

(Address) 216 Warren Ave

15- Filed MAY 11 1923 192.... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) no yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Collins M. D. (Coroner.)

5/10/23 192.... (Address) 500 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cemetery	May 12 1923
20-UNDERTAKER, John F. Denny	ADDRESS 715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

D75663

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75663

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 McHenry ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Zouck

(a) RESIDENCE NO. 1626 McHenry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo Zouck

6 DATE OF BIRTH (month, day, and year): May 7, 1841

7 AGE: Years 82 | Months — | Days 2 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Md.

PARENTS

10 NAME OF FATHER: John Ingram

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: M Kuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): M Russia

14 Informant: Thomas P Zouck

(Address) 1626 McHenry St

15 Filed MAY 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 17, 1923, to May 9, 1923.

that I last saw h— alive on May 8, 1923.

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

5/10, 1923 (Address) 1729 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hannel Balto Co Md

DATE OF BURIAL: May 13 1923

20 UNDERTAKER: W M Routson

ADDRESS 2238 W North

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, it must be carefully ascertained. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-19-21—MAT—1500 Blks.

D75664

163421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75664

38

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 10 WARD)

2-FULL NAME Robert Bordley

(a) RESIDENCE NO. 930 Hilman ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wesley —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Corine Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Recorder

15 Filed MAY 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1923, to May 6 1923

that I last saw h.. alive on May 6 1923

and that death occurred, on the date stated above, at 2 05 A. m.

The CAUSE OF DEATH* was as follows:

Aneurism aorta - dap

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic bronchitis -

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 930 Hilman St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray

(Signed) E Lowden Andrus, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel — DATE OF BURIAL May 11 1923

20 UNDERTAKER John W Henderson & Monument ADDRESS 160 N. Howard.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75665

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 Division ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Hall

(a) RESIDENCE NO. 2112 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 6, 1922

7 AGE: Years — Months: 7 — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Eugene Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary E. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Eugene Hall. 2112 Division St.

15 Filed MAY 11 1923. 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/9 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/7, 1923, to 5/9, 1923, that I last saw h alive on 5/9, 1923, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(a) Complication of Lungs

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burt R. Shutter, M. D.

5/10, 1923 (Address) 2139 O St a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W.L. Gilbert — DATE OF BURIAL: May 11 1923

20 UNDERTAKER: James H. Lewis — ADDRESS 303 Fremont

mation should be carefully supplied. AGE should be stated EXACTLY. If infants, the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-19-3[illegible] 4000 Blks.

D75666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75666

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO.) 443 W. 24th ST. 12 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel F Lambert

(a) RESIDENCE. NO. 443 W. 24th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth E Lambert

6 DATE OF BIRTH (month, day, and year) Oct 4th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Collector
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Philip Lambert
11 BIRTHPLACE OF FATHER (city or town) Switzerland
(State or country)
12 MAIDEN NAME OF MOTHER Mary Frances Hummer
13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Elizabeth E Lambert
(Address) 443 W. 24th st

15 MAY 111923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5 1923 to May 10 1923
that I last saw h[illegible] alive on May 10 1923.
and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure
(duration) yrs. 4 mos. 4 ds.
CONTRIBUTORY (Secondary) Pleuro Pneumonia
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. A. Richardson M. D.
May 10 1923 (Address) 1121 N 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 12th 1923
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

Semmler.

D75667

HEALTH DEPARTMENT—CITY OF BALTIMORE

1923 D75667

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 St. Josephs Hospital ST., 9 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida Semmler.

(a) RESIDENCE No. 1604 E. 29th. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Semmler

6 DATE OF BIRTH (month, day, and year) April 10 1882

7 AGE Years 40. Months 1 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Krell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Stahnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Anna Gabes 1604 E. 29th St.

15 Filed MAY 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4 1923 to May 10 1923

that I last saw her alive on May 10th 1923

and that death occurred, on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hosp.

Did an operation precede death? Yes Date of May 7, 1923

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) D. H. Kemp, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL May 14 1923

20 UNDERTAKER Wilhelmbach ADDRESS 502 E. Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Typhoid Illness

Spec.—1-10-21—M&T—1500 Blks.

Leake.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75668

101-00

D75668

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital. ST. 20 WARD)

2-FULL NAME Mr. Jas. Leake.

(a) RESIDENCE NO. 343 Stinson ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Margaret Leake.

6 DATE OF BIRTH (month, day, and year) May 17-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in Hair Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Thomas Leake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Margaret C. Leake

(Address) 343 Stinson St.

15 MAY 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1923, to May 9, 1923.

that I last saw him alive on May 9, 1923,

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. 5 ds. ?

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward A. Kotlowski, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 12 1923
20 UNDERTAKER	ADDRESS
George L. Schwatt	410 Cathedral St.

mation should be carefully supplied. AGE should be stated EXACTLY. ABBREVIATIONS should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1 10 21 MAT 1500 Bks.

Thelma E. Manke

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75669

CERTIFICATE OF DEATH.

175

D75669

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Hopkins Pl. ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma E. Manke

(a) RESIDENCE NO. 32 Hopkins Pl. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred X yrs. 1 mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer no

9 BIRTHPLACE (city or town) (State or country) 2213 South Ann Baltimore Md

PARENTS

10 NAME OF FATHER Otto Manke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ethel Elkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Otto Manke (Address) 2213 South Ann Baltimore

15 Filed 1 1 1929 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1923

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1923, to May 13, 1923,

that I last saw h alive on May 13, Sun., 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pneumonia

contributed the cause.

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) X yrs. X mos. 1 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of May 13 - 1923 12 M.

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) Dr K E Benson, M. D.

May 13, 1923 (Address) 6015 York Road Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Cemetery	May 17 1923
20 UNDERTAKER	ADDRESS
George L. Schmidt	1761 Eutaw Pl.

mation should be carefully supplied. AGE should be stated CAREFULLY. Information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite).; *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Eating raw sausage.

Stop—12-23-21—E.B.R.S.—400 Blks.

D75670 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D75670

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2014 City of BALTIMORE: (No. [redacted] N. Payson St., 15 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard G. Rider

(a) Residence No. [redacted] N Payson St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) Aug. 24 1921

7-AGE, 1 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jos. Rider.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Emma Conaway.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Jos Rider.
(Address) 2014 N Payson St

15- Filed MAY 11 1923 192.... ROBERT K. KRAUTER (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-11-23

17- I HEREBY CERTIFY, That I attended deceased from 5-7- 1923 to 5-11 1923 that I last saw h[redacted] alive on 5-10 1923 and that death occurred, on the date stated above, at 9-30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis
Myocarditis

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) ..... yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Inslee Wheeler M. D.

5-11 1923 (Address) 212 S Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western. DATE OF BURIAL, 5-12 1923

20-UNDERTAKER, Mrs Chas A G. Rohde ADDRESS Care Arlington Ave

Should be carefully supplied. Exact statement of OCCUPATION is very important. See In plain terms, so that it may be properly classified. instructions on back of certificates.

D75671

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75671

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Balto. Calvert St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Elmer (Elmer) n.r.r.

(Residence in Baltimore: No. 417 S. Collington ave St.; 33 yrs., 10 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~, Married (Write the word.)

6-DATE OF BIRTH, June 29, 1889 (Month) (Day) (Year)

7-AGE, 33 yrs. 10 mos. 9 ds. n.r.r.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk for Co
(b) General nature of industry, business, or establishment in which employed (or employer)..... American Ice Co

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Elmer

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Matilda Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna M. Elmer

(Address) 417 S. Collington Ave

15-

FILED MAY 11 1923 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Val. Vulv. dis. heart;

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner)

May 11, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem.	May 13, 1923
20-UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FULL NAMES must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75672

CERTIFICATE OF DEATH.

31 D75672

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Poplar Grove ST., 15 WARD)

2-FULL NAME Frances M. Dillehunt

(a) RESIDENCE NO. 1710 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 4/91

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Eisenberg

(c) Name of employer Dept. Store

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Wm B. Dillehunt

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Elmira Sewell

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Elmira Dillehunt

(Address) 1710 Poplar Grove St.

15 MAY 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17 I HEREBY CERTIFY, That I attended deceased from December, 1923, to May 10, 1923, that I last saw her alive on May 9, 1923 and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin bouillon

(Signed) H. M. Harrison, M. D.

(Address) 2733 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 5/12 1923

20 UNDERTAKER Philip Hennig — ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, ascertain CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75673

D75673

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Holbrook St. ST., 9 WARD)

2-FULL NAME George Lee Sherman Bowie Jr.

(a) RESIDENCE NO. 1315 Holbrook ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	1		10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George L. S. Bowie

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Marion Waltham

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Geo. L. S. Bowie
(Address) 1315 Holbrook St.

Filed 1923 Robert P. Harrigan, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to May 11, 1923, that I last saw him alive on May 11, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. Fullmayness, M. D.

May 11, 1923 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russistown	May 12 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

11

Spec.—1-10-21—M&T—1500 Blks.

Duplicate

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75674

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Johns Hopkins Hospital ST. 5 WARD)

2-FULL NAME Baby Ogburn

(a) RESIDENCE NO. 219 Forrest ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) April 6, 1923

7 AGE — Years ✓ Months ✓ Days 9 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Floyd L. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mattie Ogburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W. W. Gray

(Address) ~~Johns Hopkins Hospital~~

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1923, to April 15, 1923, that I last saw her alive on April 15, 1923, and that death occurred, on the date stated above, at 930 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

✓ (duration) ✓ yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) W. W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

Commissioner Health.

MAY 11 1923

mation should be carefully supplied. AGE should be stated EXACTLY. If less than one day, hours or minutes must be given. Full information must be given in answer to each question. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of burial or removal is required. See reverse side for additional space. Physicians and undertakers are required to sign certificates. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Blks.

D75675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75675

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 7 W. Glenmore Ave. WARD)

2-FULL NAME Roy Turner

(a) RESIDENCE NO. 7 W. Glenmore Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Emma Turner

6 DATE OF BIRTH (month, day, and year) June 8 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer Intercstal Ry. Co.

9 BIRTHPLACE (City or town) (State or country) Queen Anne's Md

PARENTS

10 NAME OF FATHER William Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queen Anne's Md

12 MAIDEN NAME OF MOTHER Rebecca Coates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Anne's Md

14 Informant Mrs Emma Turner (Address) 7 W. Glenmore Ave

15 May 11 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 10, 1923, that I last saw h[e] alive on May 9, 1923 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - with Acute dilatation of the Heart. (duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) Pneumonia - (duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W. H. Cappage, M. D.

May 12, 1923 (Address) 2303 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Centreville Md.	May 12 1923
20 UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 11 1923

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75676

D75676

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Urick

(a) RESIDENCE NO. 415 S. Caroline St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	64 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MAY 11 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 19 23

17 I HEREBY CERTIFY, That I attended deceased from August 4, 19 22, to May 10, 19 23, that I last saw her alive on May 10, 19 23, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Wiehe M. D.

5-11 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	May 12 1923
20 UNDERTAKER	ADDRESS
John A. Weber	1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. Any inaccuracy in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Biniasz)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75677 D75677

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 S. Chester St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Biniasz

(a) Residence No. 222 S. Chester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Nov 5 1907

7-AGE. 15 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): school

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Bartlomij Biniasz

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Josphine Wilczynski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant) Bartlomij Biniasz

(Address) 222 S. Chester

15- Filed MAY 14 1923 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 10/23

17- I HEREBY CERTIFY, That I attended deceased from April 24 1923 to May 10 1923

that I last saw her alive on May 10 1923

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Disease

(Duration) 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. D. Meer M. D

5/11/1923 (Address) 408 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: May 14 1923

20-UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

MAY

Should be carefully classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75678

D75678

CERTIFICATE OF DEATH.

REGISTERED NO. C 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame of Maryland St.: 7 1 WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Valeria Zwerger

(Residence in Baltimore: No. Charles Street Ave St.: 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, August 29, 1862
(Month) (Day) (Year)

7-AGE, 60 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teaching
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Rochester, N. Y.

PARENTS.

10-NAME OF FATHER, George A. Zwerger

11-BIRTHPLACE OF FATHER (State or Country), Rochester, N. Y.

12-MAIDEN NAME OF MOTHER Josepha Brechler

13-BIRTHPLACE OF MOTHER (State or Country), Hessen Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister M. Philomena

(Address) Charles St. Ave. Balto. Md.

15-

Filed ..... 191...

1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 5 1923, to May 10 1923, that I saw h alive on May 6 1923 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(a) apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Contracted Kidney

(Duration) yrs. mos. ds.

(Signed) Chas. Bonnicastle M. D.

May 8, 1923 (Address) 4706 Harford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenstown Private — DATE OF BURIAL, May 12, 1923

20-UNDERTAKER Frank A. Fink — ADDRESS 910 N. Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75679

D75679

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Ruxton Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Alfred Bell Sellman

(Residence in Baltimore: No. 1823 Ruxton Ave St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Widowed

6-DATE OF BIRTH. June (Month) 10 (Day), 1850 (Year)

7-AGE. 72 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dealer of Medicine
(b) General nature of industry, business, or establishment in which employed (or employer): 54

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. John Jeremiah Moore Sellman

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Ann Elizabeth Bell

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Reginald Owen Sellman

(Address) 1823 Ruxton Ave.

15- Robert P. Harrison, MAY 11 1923, 191 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 10 1923, to May 10th 1923, that I saw him alive on May 10th 1923, and that death occurred, on the date stated above, at 9:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. mos. ds.

(Signed) J. Edward Crowell M. D.

May 10th 1923 (Address) 4 a W. Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. May 12, 1923

20-UNDERTAKER Chas. F. Evans & Son ADDRESS 1128 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75680 ✓ D75680

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH St. Joseph's Hosp. 7

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Clark

(a) RESIDENCE NO. 1031 N. Broadway ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice F. Clark

6 DATE OF BIRTH (month, day, and year) Oct 1 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	64	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) 042

(c) Name of employer .....

9 BIRTHPLACE (City or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jas A. Clark

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth A. Wilson

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md.

14 Informant Alice F. Clark

(Address) 1031 N. Broadway

15 Filed ..... 19 ..... Robert P. Garrison, Registrar

Burial Permit Issued.

MAY 11 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1923, to May 9, 1923, that I last saw him alive on May 9, 1923, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kreger, M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 5/12 1923

20 UNDERTAKER Chas E. Evanston

ADDRESS 118 W. North Royalave

mation should be carefully supplied. AGE should be stated EXACTLY. Physicians should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75681

CERTIFICATE OF DEATH.

90

D75681

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 N. Broadway ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Taylor

(a) RESIDENCE NO. 1227 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Mc Dewitt Taylor

6 DATE OF BIRTH (month, day, and year) May 20 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer) 12

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Wm Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary J. Taylor (Address) 1227 N. Broadway

15 Robert P. Harrison Registrar

MAY 11 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 - 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to May 9, 1923, that I last saw him alive on 8th May, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cardio - vascular disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of right heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination of heart and kidneys

(Signed) Arthur J. Barrett, M. D.

5/10 1923 (Address) 2000 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 12 1923

20 UNDERTAKER Chas J. Rouse & Son — ADDRESS 118 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75682 D75682

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 35 Powhatan ST.; W. WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph E. Clark.

(Residence in Baltimore: No. 35 Powell Ave. St.; 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED. M (Write the word.)

6-DATE OF BIRTH, April 3, 1875 (Month) (Day) (Year)

7-AGE, 48 yrs. 1 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Street Car
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph Clark.

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Susan Perlay

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H. Clark

(Address) 35 Powell Ave

15-

Robert P. Harrison

(Date) 191.

Burial Permit Clark. Registrar.

11 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6th 1923, to May 9th 1923, that I saw h[illegible] alive on May 9th 1923, and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) C. Bright's

(Duration) yrs. mos. ds.

(Signed) Santard A. Dent M. D.

5/11, 1923 (Address) Arcola Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, May 12, 1923

20-UNDERTAKER Harry H. Witzke ADDRESS 1314 Lombard

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—B.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75683 ✓ D75683

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Winston

(a) Residence No. 1107 McCullough St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Married

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1882

7-AGE.	If LESS than 1 day.
40 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Richmond, Va.

PARENTS.

10-NAME OF FATHER, Richard Scott

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, Mary Scott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Record

(Address)

15- 1923 Robert F. Harrison, 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 9, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 14 1923 to May 9 1923

that I last saw h... alive on May 9 1923

and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

leading to heart failure

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Syphilis (?)

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. McKay M. D

5-10-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	5-12. 1923
20-UNDERTAKER.	ADDRESS
David Easton	916 Pennsylvania Ave

Exact statement of OCCUPATION is very important. Should be properly classified. Use plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75684

CERTIFICATE OF DEATH.

9 D75684

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 935 S Kenwood Ave ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucas W. H Glock

(a) RESIDENCE. No. 935 S Kenwood Ave ST. 1 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? 14 yrs. — mos. — ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Child

6 DATE OF BIRTH (month, day, and year) Oct 12-1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Glock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marie Lucasen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) John Glock 935 S Kenwood Ave

15 Robert P. Harrison, Registrar

MAY 11 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to May 11, 1923.

That I last saw h— alive on May 11, 1923.

and that death occurred, on the date stated above, at 2 — p.m.

The CAUSE OF DEATH* was as follows:

I (Bronchial pneumonia (primary)
(pulmonary congestion)
(duration) 5 hrs

CONTRIBUTORY (Secondary) Pertussis
(duration) 1½ mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

5/11, 1923 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — St Mary's Cem — DATE OF BURIAL May 12 1923

20 UNDERTAKER Stephen F Falkowski — ADDRESS 1008 S Kenwood Ave

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75685

CERTIFICATE OF DEATH.

159-002 D75685

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Augusta Av ST., 20 WARD)

2-FULL NAME Mary Theresa Rogers

(a) RESIDENCE NO. 2 Augusta Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9 '23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Herbert A. Rogers

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Theresa A Dennin

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Herbert A Rogers
(Address) 2 Augusta Av

15 MAY 11 1923 Robert P. Harrison, Registrar
19 .....
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1923, to May 11, 1923,
that I last saw h[illegible] alive on May 10, 1923,
and that death occurred, on the date stated above, at 9- A. m.
The CAUSE OF DEATH* was as follows:

Congenital Debility

Foramen Ovale not closed

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. L. Fair, M. D.

, 19 (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 12 1923

20 UNDERTAKER Margaret L. Flynn

ADDRESS 1422 Light St.

AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75686

CERTIFICATE OF DEATH.

128 D75686

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 112-West-Mulberry-St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Frank Hale

(a) Residence No. 112-W-Mulberry-St. St., 4 Ward (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 77 yrs. 5 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eugenie H. Hale

6-DATE OF BIRTH (month, day and year) Dec-11-1845

7-AGE. 77 yrs. 5 mos. 0 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) " " " " " "

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country). Phila., Pa. Penna.

PARENTS.

10-NAME OF FATHER. William Hale

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Rising Sun Maryland

12-MAIDEN NAME OF MOTHER, Mary Leamy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Rising Sun Maryland

11- (Informant) Mrs. E. H. Boltsler (daughter)
(Address) 112-W-Mulberry-St., City

15- Filed ..... 192 Robert P. Harrison, Registrar.

May 1 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 11/23

17- I HEREBY CERTIFY, That I attended deceased from April 30 1923 to May 11 1923

that I last saw h. alive on May 11 1923

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. ....mos. 12 ds

CONTRIBUTORY (Secondary) Don't Know

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D

5-14-1923 (Address) 1127 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. May-14-23

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOOSTER, Supt.)

ADDRESS 108 W. NORTH AVE.

Exact statement of OCCUPATION is very important and should be carefully supplied. Exact statement of CAUSE OF DEATH should be properly classified. Exact statement of CAUSE OF DEATH should be in plain terms, so that it may be properly classified. See instructions on back of certificates.

D75687 HEALTH DEPARTMENT—CITY OF BALTIMORE D75687

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 844 S. Sharp St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Barksdale. (C). 6.

(Residence in Baltimore: No. 844 S. Sharp St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)

7-AGE. 65 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER. ------ Booker (C).

11-BIRTHPLACE OF FATHER. (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER. Millie Allen (C).

13-BIRTHPLACE OF MOTHER. (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Matthews (C) (daughter).

(Address) 844 S. Sharp St.

15- 12 1923

Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Leinhardt M. D. (Coroner.)

May 10, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Charlotte County Va	May 13 1923

20-UNDERTAKER.	ADDRESS
J. H. Brown & Son	1082 W. Monroe St

Route, Bay Line to Norfolk to Charlotte County Va

N.B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 X 188 003

D75688

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Vs Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva G. Murray

(Residence in Baltimore: No. 1335 Shellcross Ave. Wilmington Del St.; yrs. ..... mos. ...../..ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	[illegible]

6-DATE OF BIRTH. July 28/1867
(Month) (Day) (Year)

7-AGE. 55 yrs. 9 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). York Co. PA

PARENTS.

10-NAME OF FATHER. Samuel Grier

11-BIRTHPLACE OF FATHER. (State or Country). Harford Co. Md

12-MAIDEN NAME OF MOTHER. Annie Kilgour

13-BIRTHPLACE OF MOTHER. (State or Country). York Co. Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W.J.Murray (husband)

(Address) Wilmington Del.

15- Robert P. Harrison, Registrar.
MAY 12 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11/23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Hemorrhage- both thighs crushed- rt arm Fract. face bruised Struck by auto truck

(Inquest to be held May 16/23) (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Haller M. D.
(Coroner.)

5/11/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	May 12 1923

20-UNDERTAKER.	ADDRESS
Robt J Turner Inc	1412 W Baltimore

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75689

CERTIFICATE OF DEATH.

21 90

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1517 Denver St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Fontz. 61 9 0

(Residence in Baltimore: No. 1517 Denver St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single

6-DATE OF BIRTH. August 9th. 1861. (Month) (Day) (Year)

7-AGE. 61 yrs. 9 mos. 0 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Fontz.

11-BIRTHPLACE OF FATHER, (State or Country). Washington D. C.

12-MAIDEN NAME OF MOTHER, Sarah Gaebel.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Kidwell. (sister)

(Address) 1517 Denver St.

15- Robert P. Harrison, Registrar.

MAY 21923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9th. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis, fibrosis & calcification of Coronary Arteries. Myocardial insufficiency, Acute dilatation of the heart. (Infant only) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto H. Reinhardt M. D. (Coroner)

May 11 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	5-12 1923
20-UNDERTAKER, Robt A Turner Inc	ADDRESS 1442 N Broadway

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75690

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Bessie Anderson

(Residence in Baltimore: No. 1004 Sarah Ann St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH. 1885
(Month) (Day) (Year)

7-AGE. 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). family

9-BIRTHPLACE, (State or Country). Talbot Co Md

PARENTS.

10-NAME OF FATHER. John Warner

11-BIRTHPLACE OF FATHER, (State or Country). Talbot Co Md

12-MAIDEN NAME OF MOTHER. Caroline Scott

13-BIRTHPLACE OF MOTHER, (State or Country). Talbot Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Percy Warner

(Address) 1013 Wagon alley

15. 12 1923 Robert F. Harrison, 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jo Burns over Body & Legs accident,
Coal oil Lamp Explosion
(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) James M Faulkner M. D.
(Coroner.)

May 11 1923 (Address) 704 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death. 1 yrs. mos. 4 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1004 Sarah Ann St

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	May 12th 19
20-UNDERTAKER.	ADDRESS.
A Jones	11 S Gilmor

24

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75691

CERTIFICATE OF DEATH.

101-60 D75691

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4201 Dunbar ✗ Ave WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Katie A. Dubbs,

(a) RESIDENCE. NO. 4201 Dunbar ✗ St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Daniel Dubbs

6 DATE OF BIRTH (month, day, and year): Aug-20-1872

7 AGE: Years 50 | Months 8 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Publicity Agt.

(b) General nature of Industry, business, or establishment in which employed (or employer): Clerical

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Md.-Balto.

PARENTS

10 NAME OF FATHER: F. H. Harbaugh.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: K. E. Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Daniel Dubbs

(Address)

15 Filed: MAY 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May-10- 1923

17 I HEREBY CERTIFY, That I attended deceased from May-4- 1923, to May 10 1923, that I last saw h~~er~~ alive on May-10 1923, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (~~Septic~~).

Labor, with extension Bronchus. Diffuse through both lungs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) — yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Wrightcale, M. D.

(Address) 2726 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: May 12 1923

20 UNDERTAKER: James B. Payne — ADDRESS: 1324 Eutaw St.

nation should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it THON is very important. See instructions on

CAUSE OF DEATH is properly classified. Exact statement of OCCUPA- that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75692

CERTIFICATE OF DEATH.

162 D75692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S Calhoun ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jo Bowen

(a) RESIDENCE NO. 317 S Calhoun ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 9 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Howard E Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Maryland

12 MAIDEN NAME OF MOTHER Catherine A Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant Howard E Bowen

(Address) 317 S Calhoun st

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1923, to May 11th, 1923.

that I last saw her alive on May 11th, 1923

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

1 day 20 hours 45 minutes

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhagic Diseade of newborn

(duration) ..... yrs. ..... mos. 4 hours ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Kleibel M.D.

5/11, 1923 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 12 1923
20 UNDERTAKER	ADDRESS.
John F Denny	715 Light St

information should be carefully supplied. AGE should be stated EXACTLY. Information must be complete so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12 1923

Spec.—1-10-21 M&T 1500 Blks.

D75693

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75693

CERTIFICATE OF DEATH.

91-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3929 Ridgewood Ave St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina Kneisch

(a) RESIDENCE NO. 3929 Ridgewood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of John Kneisch

6 DATE OF BIRTH (month, day, and year) May 21, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	83	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Knaesch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Krumma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Kneisch

(Address) 3929 Ridgewood Ave

15 Filed ROBERT F. [illegible] 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17

I HEREBY CERTIFY, That I attended deceased from April 10th, 1923, to May 11th, 1923, that I last saw h[illegible] alive on May 11th, 1923, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 5 yrs. — mos ~ ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 1 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J B Saunders M. D.

5/24, 1923 (Address) 219 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 14 1923
20 UNDERTAKER Harry W. Ehlen	ADDRESS W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12 1923

HEALTH DEPARTMENT--CITY OF BALTIMORE

D75694 D75694

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 3401 Forest Park ave ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Marion W. Engel

(Residence in Baltimore: No. 3401 Forrest Park Ave St.; 12 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Dec 14 (Month) (Day), 1891 (Year)

7 AGE: 31 yrs. 4 mos. 27 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER: Wm Joseph Walsh

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Adelia Mahle

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr John H. Engel

(Address) 3401 Forest Park Ave

15 Robert F. Harrison, Burial Permit Clerk, 191 REGISTRAR

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 12 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 11 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1922 to May 11 1923 that I saw h[illegible] alive on May 11, 1923 and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rhino pharynx and right Eust Maxilla

(Duration) yrs. 11 mos. ds

Contributory (SECONDARY) Pneumonia [illegible] Bronchitis (Duration) yrs. mos. 1 ds.

(Signed) Lee Cohen M. D.

May 11, 1923 (Address) 1520 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: May 14 1923

20 UNDERTAKER: Geo. Weber Son — ADDRESS: 2303 Edmon

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1922
16
D75693

D75695

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 Portland. ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter D. Hof.

(a) RESIDENCE NO. 708 Portland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (or) WIFE of — none

6 DATE OF BIRTH (month, day, and year) Nov 22-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John. D. Hof.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Fuchs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) John. Hof. 708 Portland St

15 Filed 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to May 10, 1923, that I last saw h alive on May 10, 1923, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Rheumatism (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Coulter, M. D.

May 11, 1923 (Address) 5 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 5-14 1923

20 UNDERTAKER E. W. Hale 115 — ADDRESS E. Mad. St

mation should be carefully supplied. AGE should be stated EXACTLY. Physician's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75696

D75696

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 Dolphin ST.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and add out No. 18.)

2-FULL NAME Cornelia Anderson.

(Residence in Baltimore: No. 527 Dolphin St.; 61 yrs., — mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1862 (Year)

7-AGE 61 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. A. L. Gaines

(Address) 1622 Mc Culloh

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

12 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 3 1923, to May 9 1923, that I saw h[er] alive on May 6 1923, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(Duration) yrs. 1 mos. da.

(Signed) W. T. Carr M. D.

May 9, 1923 (Address) 515 Tyson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. | DATE OF BURIAL, 5-13-, 1923

20-UNDERTAKER George H. Holland | ADDRESS 1631 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75697

CERTIFICATE OF DEATH.

57 D75697

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N Eden St., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene Jones Barnes

(Residence in Baltimore: No. 706 N. Eden St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, unknown (Month) (Day), 1881 (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Edward Watkins son in Law

(Address)..... 706 N. Eden St

15-

Filed....., 191.....

Registrar.

MAY 21 1923 Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 9 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1923, to May 9 1923, that I saw h[illegible] alive on May 9 1923, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Coma & Acidosis

..... (Duration) ..... yrs. ..... mos. couple ds.

(Signed) R. T. Young M. D.

5/19, 1923 (Address) 1429 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, May 12., 1923

20-UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1725 Eastland Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75698 D75698

CERTIFICATE OF DEATH.

X 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 E. Madison ST., 7 WARD)

2-FULL NAME Charles Brinkley Waller.

(a) RESIDENCE NO. 1649 E. Madison ST., WARD Water View Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow

6 DATE OF BIRTH (month, day, and year) April 15 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	97			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work labor odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) middle dep va

PARENTS

10 NAME OF FATHER Thomas Waller

11 BIRTHPLACE OF FATHER (city or town) (State or country) va

12 MAIDEN NAME OF MOTHER Annie Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) va

14 Informant William Waller
(Address) 1649 E Madison St

15 Filed 5-11 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10- 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-7-23 1923 to 5-10- 1923.

that I last saw him alive on 5-10- 1923

and that death occurred, on the date stated above, at 1,30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Hargis, M. D.

5-11-, 1923 (Address) 611 N Carol

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL middle dep water view va

DATE OF BURIAL 13 May 1923

20 UNDERTAKER Edward Bryson

ADDRESS 1631 orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

12 1923

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75699

D75699

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Belair Rd ST., 8 WARD)

2-FULL NAME Julia V. Schneller

(a) RESIDENCE NO. 2013 Belair Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Schneller

6 DATE OF BIRTH (month, day, and year) Nov. 13-1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
40	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (37)

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

PARENTS

10 NAME OF FATHER John H. Smith

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Virginia Brown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant William H. Schneller

(Address) 2013 Belair Road

MAY 12 1923 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1922, to May 10, 1923, that I last saw h[illegible] alive on May 9, 1923 and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Nephritis chronic (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

May 12, 1923 (Address) 1 E. Cold Spring Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	May 14 1923
20 UNDERTAKER	ADDRESS
George L. Schwab	1911 Eutaw Pl.

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Wilkins)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75700

D75700

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1657 Thomas Ave ST., 15 WARD)

2-FULL NAME Ben N. S. Williams

(a) RESIDENCE NO. 1657 Thomas Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca R. Wray

6 DATE OF BIRTH (month, day, and year) July 26 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edwd Wilkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Hewitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Raymond R. Hillegas
(Address) Chas. & Mt. Md.

MAY 12 1923 Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922 to May 12, 1923

that I last saw h-me alive on May 12, 1923

and that death occurred, on the date stated above, at 7 20 a.m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis & Oedema of Lungs (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Obvs. & Exam.

(Signed) John L. Graham, M. D.

(Address) 1219 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehmann's May 17 1923

DATE OF BURIAL

20 UNDERTAKER Wm Cook 502 E. Fayette

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75701

CERTIFICATE OF DEATH.

38

D75701

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Kodastz

(a) Residence No. 432 S. Bond St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1877

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER. Hebro Kodastz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

11- (Informant) Municipal Hospital Records

(Address)

13- Filed ..... 19.... Robert P. Harrison, Registrar.

MAY 12 1923 Burial Permit Clerk. 0571

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 10, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 9 19 23 to May 10 19 23

that I last saw him alive on May 9 19 23

and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure from

Chronic Myocarditis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. A. McKay M. D

5-10-19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND

DATE OF BURIAL. ..... 19....

20-UNDERTAKER. Commissioner Health. Dept. H. WOODALL.

ADDRESS MAY 12 1923

Should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—MAT—1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75702

CERTIFICATE OF DEATH.

D75702

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST. 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Landers

(a) RESIDENCE NO. 525 Vincent Ave, ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	84	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Isaac Landers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Indies

12 MAIDEN NAME OF MOTHER Lucy Hill

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Carroll Co., Md.

14 Informant Municipal Hospital Records.
(Address) UNIVERSITY OF MARYLAND.

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MAY 12 1923

0372

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1923, to May 10, 1923,

that I last saw him alive on May 10, 1923,

and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prostate Hypertrophy ? ?

..... (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted ?
If not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No Suppression of Urine

What test confirmed diagnosis?

(Signed) Chas. G. M. Shifler M. D.

, 19 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Commissioner Health.

DATE OF BURIAL

19

ADDRESS

MAY 12 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75703

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 232 E. Cross St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... William Coster. 60

(Residence in Baltimore: No. 232 E. Cross St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. September 4th. 1846. 1.....
(Month) (Day) (Year)

7-AGE. 76 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk.
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Calvert Co. Md.

PARENTS.

10-NAME OF FATHER. William Coster.

11-BIRTHPLACE OF FATHER, (State or Country). Calvert Co. Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Hooper.

13-BIRTHPLACE OF MOTHER, (State or Country). Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Mary E. Coster. (wife)

(Address)..... 232 E. Cross St.

15- Robert P. Harrison,

Filed..... 192.....

Burial Permit Clerk. Registrar.

5 12 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 10th. 1923. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

May 11th 192 3 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery	May 17th 1923
20-UNDERTAKER.	ADDRESS
E. J. Fanning & Son	1460 Battery Av.

If it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75704

CERTIFICATE OF DEATH. D75704

REGISTERED NO. 14

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen G. McComas

(a) RESIDENCE NO. Glenarm Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amos P McComas

6 DATE OF BIRTH (month, day, and year) Nov 7, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Glenarm Maryland

PARENTS

10 NAME OF FATHER John Beckhaus

11 BIRTHPLACE OF FATHER (city or town) Lancaster Co (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary C Russell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Husband & Brother

(Address)

15 Filed ..... 19 ..... Robert F. Carrison, Registrar

Burial Permit Clerk.

12 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17

I HEREBY CERTIFY, That I attended deceased from May 3 .1923. to May 11 .1923.

that I last saw h er alive on May 11 .1923.

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Circulatory Collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Arm Md

DATE OF BURIAL May 12 1923

20 UNDERTAKER E LeRoy Stiffler

ADDRESS 1252 North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks. 75705

HEALTH DEPARTMENT—CITY OF BALTIMORE

162159 D75705

CERTIFICATE OF DEATH. X 32

D75705

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar Westmoreland

(a) RESIDENCE No. 612 "T" St. N.W. St. Washington, D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) United States

PARENTS

10 NAME OF FATHER Edgar P.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Marion Millburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Massachusetts

14 Informant JOHNS HOPKINS HOSPITAL (Address) Friend

15 Filed MAY 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1923, to May 12, 1923, that I last saw him alive on May 12, 1923, and that death occurred, on the date stated above, at 2A. m.

The CAUSE OF DEATH* was as follows:

Generalized tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Tubercle in cerebellum

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Apr. 7 1923

Was there an autopsy? yes

What test confirmed diagnosis? Operation—tubercle in cerebellum

(Signed) F. H. Reichert, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL May 18 23

20 UNDERTAKER George H. Holland ADDRESS 1631 [illegible]

I hereby certify that I have carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

75706 D75706

HEALTH DEPARTMENT—CITY OF BALTIMORE D75706

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 78 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell B. Poitiaux

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28th WARD. Richmond Va.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? 66 yrs. 3 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Rushwood Spotsylvania Co

PARENTS

10 NAME OF FATHER Eugene Portieux

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va

12 MAIDEN NAME OF MOTHER Emily Noyes

13 BIRTHPLACE OF MOTHER (city or town) Georgetown D C (State or country)

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 MAY 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3 1923, to May 12 1923, that I last saw h-- alive on May 10 1923, and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular (Mitral) Disease of Heart

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Mem - Diffus. Psychosis (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Staunton Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

May 12 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	May 17 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOOD, Supervisor) ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75707

CERTIFICATE OF DEATH.

164

D75707

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2050 Linden Ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Slicer Gues

(a) Residence No. 2050 Linden Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widow, Widower or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benj F Gues

6-DATE OF BIRTH (month, day and year) March 4 1831

7-AGE. 91 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore

(State or Country)..... Md

PARENTS.

10-NAME OF FATHER. William Slicer

11-BIRTHPLACE OF FATHER (city or town)..... Md

(State or Country).....

12-MAIDEN NAME OF MOTHER. Margaret Weidefield

13-BIRTHPLACE OF MOTHER (city or town)..... Md

(State or Country).....

14-

(Informant)..... Josephine Gues

(Address)..... 2050 Linden Ave

15-

Filed MAY 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 11 1923

17- I HEREBY CERTIFY, That I attended deceased from May 6, 1923, to May 11, 1923, that I last saw h.. alive on May 9, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Senility

.....(Duration) — yrs. — mos. ds.

CONTRIBUTORY — (Secondary)

.....(Duration) — yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John D. Krug, M. D.

May 12 1923 (Address) 1425 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	May 14, 1923
20-UNDERTAKER	**ADDRESS**
John O Mitchell	1201 W Fayette St

Should be carefully supplied. Note should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75708

CERTIFICATE OF DEATH. 74-001 D75708

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Barney

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
51	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 / 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 MAY 13 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1922, to May 10, 1923, that I last saw her alive on May 9, 1923, and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. A. McCay, M. D.

5-13-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forbury Cemetery	May 13th 1923
20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75709

CERTIFICATE OF DEATH. 90

D75709

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2108 W North Ave WARD 12)

2-FULL NAME Mrs. Leah Pointer

(a) RESIDENCE NO. 2108 W. North Ave WARD 12th

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed ~~or divorced~~ HUSBAND of (or) WIFE of John W Parlin

6 DATE OF BIRTH (month, day, and year) June 17 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of Industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Michel Wiard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Potterfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Vernon Parker (Address) 2108 W North Ave

15 MAY 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from 3 or 4 years ..... 19.... that I last saw her alive on May 11th 1923. and that death occurred, on the date stated above, at 10:25 P. m.

The CAUSE OF DEATH* was as follows: Cardiac dilatation, arterio sclerosis + anasarca.

(duration) yrs. 6 mos + ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Nothing more than clinical and physical symptoms.

(Signed) E. H. Hoffman, M. D.

(Address) 2462 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park. DATE OF BURIAL May 14th 1923

20 UNDERTAKER Josiah Sykes ADDRESS 1600 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75710

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-002 D75710

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 343 Sycamore av ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John H. Miles

(Residence in Baltimore: No. 343 Sycamore av ST. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept. (Month) 16 (Day), 1850 (Year)

7 AGE: 72 yrs. 7 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): O'W

9 BIRTHPLACE (State or country): Va

PARENTS

10 NAME OF FATHER: David Miles

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Young

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wesley Miles

(Address) 1343 Mosher St

15 MAY 13 1923, 191 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 11th (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22, 191.., to May 11th 1923
that I saw h in alive on May 10, 1923
and that death occurred, on the date stated above, at 3 15 m.
The CAUSE OF DEATH* was as follows:

Abscess left lung

(Duration) ..... yrs. 4 mos. ..... ds

Contributory (SECONDARY) Bronchitis

(Duration) 1 yrs. 1 mos. ..... ds.

(Signed) C. V. Gabriel M. D.

May 13, 1923 (Address) 2403 Frederick Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mays A

DATE OF BURIAL: May 14, 1923

20 UNDERTAKER: A S Marshall

ADDRESS: 3539 Gall Rd.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Varholy.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75711

D75711

CERTIFICATE OF DEATH

036-005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Varholy

(a) RESIDENCE NO. 16 Church (Usual place of abode) Curtis Bay WARD Curtis Bay, Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Feb. 24 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis F. Varholy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vienna.

12 MAIDEN NAME OF MOTHER Anna Grubitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant JOHNS HOPKINS HOSPITAL (Address) Woods.

15 Filed MAY 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1923, to May 10th, 1923, that I last saw him alive on May 10th, 1923, and that death occurred, on the date stated above, at 8 32 P. m.

The CAUSE OF DEATH* was as follows:

Primary Pulmonary abscess & tuberculosis of Rt. Kidney

X (duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Surgical Shock (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 5. 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Confirmed diagnosis

(Signed) Franklin F. Johnson, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL May 14 1923

20 UNDERTAKER Emil L. Brockhoff — ADDRESS 1906 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

162632 D75712

CERTIFICATE OF DEATH.

47 D75712

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., (6 WARD)

2-FULL NAME Carrie Casey

(a) RESIDENCE NO. 416 N. Wolfe ST., Citizen

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William H. Casey

6 DATE OF BIRTH (month, day, and year) Sept. 11, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER E.B.C. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Bargan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL Records. (Address)

15 MAY 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from March 29 1923 to May 12 1923, that I last saw her alive on May 12, 1923 and that death occurred, on the date stated above, at 7.45 A.m.

The CAUSE OF DEATH* was as follows:

Cancer of breast (left) followed by generalized carcinomatosis

(duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Secondary anemia; chronic

(duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E.B. Andrus, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: May 15 1923

20 UNDERTAKER: Zurkler Zurkler — ADDRESS: 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75713

CERTIFICATE OF DEATH.

90 D75713

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 104 S Arlington Ave ST., 18 WARD)

2-FULL NAME Margaret Estella Culver

(a) RESIDENCE NO. 1104 S Arlington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas M. Culver

6 DATE OF BIRTH (month, day, and year): Dec 12, 1867

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
55	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: Herman Wersing

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Catherine Sahm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Md

14 Informant: Chas. W. Culver

(Address) 104 S. Arlington

15 Filed MAY 13 1923 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1923

17

I HEREBY CERTIFY, That I attended deceased from April 23 1923 to May 11 1923, that I last saw him alive on May 11 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary): Mitral Heart Disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. A. O'Neill M. D.

5/12 1923 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 14 1923

20 UNDERTAKER: John J Fields — ADDRESS: 1205 W Fayette

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75714

CERTIFICATE OF DEATH.

118-002 D75714

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 W Patterson Pk Av ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hinda Schalowitz

(Residence in Baltimore: No. 20 W. Patterson Park Av St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1832 (Year)

7-AGE.	If LESS than 1 day,
91 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country). Riga Russia

PARENTS.

10-NAME OF FATHER. Israel Goodman

11-BIRTHPLACE OF FATHER (State or Country). Riga Russia

12-MAIDEN NAME OF MOTHER Leah Goodman

13-BIRTHPLACE OF MOTHER (State or Country). Riga Goodman

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard Feldman

(Address) 11 W. Chesapeake Av

15- FILED MAY 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12 1923, to May 12 1923, that I saw her alive on May 12 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Old Age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alfred A. Rondeck M. D.

May 13, 1923 (Address) 2 E Patterson Park Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Nathanael — DATE OF BURIAL, May 15 1923

20-UNDERTAKER Jack Lewis — ADDRESS 1434 E Baltimore St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75715

CERTIFICATE OF DEATH.

90 D75715

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2800 Suffolk Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip G. Kelly

(a) RESIDENCE. No 2800 Suffolk Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Wilhelmina Kelly

6 DATE OF BIRTH (month, day, and year) Oct 6 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale 166

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Patrick Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan

12 MAIDEN NAME OF MOTHER Johanna Gorman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

14 Informant George H. Gorn
(Address) 1005 Cathedral St

15 Filed MAY 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1923, to May 11, 1923, that I last saw h alive on May 11, 1923, and that death occurred, on the date stated above, at 11 AM P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Gorn, M. D.

. 19 (Address) 1005 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 14 - 1923
20 UNDERTAKER	ADDRESS 317 N.
H. C. Brauning Son	Schroeder St

AGE should be carefully supplied. PHYSICIANS should state information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75716

D75716

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Harlem Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Thiem

(a) RESIDENCE NO. 905 Harlem Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~
HUSBAND of
(or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Sept 7 1838

7 AGE	Years	Months	Days	If LESS than 1 day ... hr. or ... min.
	84	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler Case Maker

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Thiem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adelaide Hoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Katerragel
(Address) 905 Harlem Ave

15 Filed MAY 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH CARE AND PRECISION. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1923, to May 6, 1923.

that I last saw h[illegible] alive on May 6th, 1923.

and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

1 Heart failure

one week (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) John F Thiemer M. D.

MAY 13 1923 (Address) 1000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 5/15 1923

20 UNDERTAKER Gerald Leale

ADDRESS 2700 Edmondson Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75717 ✓ D75717

CERTIFICATE OF DEATH.

D75717
1-PLACE OF DEATH

129
REGISTERED NO.

CITY OF BALTIMORE: (No. 319 S Bruce ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A Emmart

(a) RESIDENCE NO. 319 S Bruce ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha A. Emmart.

6 DATE OF BIRTH (month, day, and year) unknown 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labr. work helper.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Emmart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Martha A Emmart
(Address) 319 S Bruce St

15 MAY 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2 1923, to May 11 1923, that I last saw h— alive on May 10 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hospital Findings

(Signed) [illegible] M. D.

5/13 1923 (Address) 1779 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 14 1923
20 UNDERTAKER John J Bowman & Son Del J Bowman	ADDRESS 901 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. – 1-10-21 – M&T – 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75718

REGISTERED NO. D75718

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1381 N Gilmor ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Crist

(a) RESIDENCE NO. 1381 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	3.	9	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harry Crist.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Tydow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

11 Informant Mrs Mary Crist

(Address) 1381 N Gilmor St.

15 Filed MAY 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr. 15 1923, to May 11 1923, that I last saw him alive on May 10 1923, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Measles 3 weeks ago Whooping Cough 2½ mos

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jennie N Brown, M. D.

May 12 1923 (Address) 1223 N Schroeder St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents Cem DATE OF BURIAL May 14 1923

20 UNDERTAKER John F Cowan & Son ADDRESS

John F Cowan 901 Hollins St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75719

CERTIFICATE OF DEATH.

D75719

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Woodley ST. 16 WARD)

2-FULL NAME Katharine McCarthy

(a) RESIDENCE. No. 1107 Woodley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 29 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Mc Carthy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Stella Link

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Chas Mc Carthy
(Address) 1107 Woodley St

15 FILED MAY 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to May 12, 1923, that I last saw he alive on May 12, 1923, and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Tormitus, Teithing, Convulsions.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Paresis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas A Fetterhoff M. D.

. 19 (Address) 1807 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	May 14 1923
20 UNDERTAKER Edw J Cowan & Son	ADDRESS 901 Hollins St

Edw J Cowan

NAME PLAINLY; mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

should be stated EXACTLY. PHYSICIANS should state
may be properly classified. Exact statement of OCCUPA-
back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

May 13/2-

This child was one of twins has always had a bad color since birth. She has suffered from frequent attacks of bronchitis has had measles, was very sick with them. Has had trouble teething. I saw her yesterday afternoon and she looked better. Later in the evening I was called to treat her for convulsions and at 11.15 she died

C. A Fetterhoff M.D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75720

CERTIFICATE OF DEATH.

31 D75720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rados

(a) RESIDENCE NO. 711 S. Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Constantin Rados

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records

(Address) M.T.H.

15 MAY. 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to May 12, 1923,

that I last saw him alive on May 12, 1923,

and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Badoglucco M. D.

5-15-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL May 14 1923

20 UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75721

CERTIFICATE OF DEATH.

41 D75721

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 S Luzerne St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frederick Wm Heumann

(a) Residence No. 714 S Luzerne St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (~~Write the~~ word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 4 1922

7-AGE, .../...yrs.../...mos.9...ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Geo A Heumann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Rose Frier

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Geo C Heumann

(Address) 714 S Luzerne

15- MAY 14 1923. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 13 1923

17- I HEREBY CERTIFY, That I attended deceased from 7 May, 192?, to 13 May, 192?, that I last saw h[illegible] alive on 13 May, 192?, and that death occurred, on the date stated above, at 4.30 a. m. The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Blk Blindness incipient
Pyelitis & Ureteritis
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Culture Blood & Urine

(Signed) [illegible], M. D.

, 19 (Address) 301 S Elwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL, May 16, 1923

20-UNDERTAKER, Wm Cook — ADDRESS 502 E Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75722

CERTIFICATE OF DEATH.

31 D75722

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 E. 28th ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustava A Kruemmel

(a) RESIDENCE NO. 1511 E 28th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augusta E Kruemmel

6 DATE OF BIRTH (month, day, and year): May 18 1856

7 AGE — Years: 66 — Months: 11 — Days: — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer): 073

(c) Name of employer: United Rail R. Co

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Kruemmel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Augusta E Kruemmel (Address) 1511 E 28th St

15 Filed MAY 14 1923 ROBERT N. KRAUTER, Registrar

Riley Brelsford Lahey Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1923

17 I HEREBY CERTIFY, That I attended deceased from last time 3 weeks ago, 19 23, to May 11, 19 23,

that I last saw him alive on May 10 1923, 19 ..., and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmon Tuberculosis

(duration) ..... yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W Braley, M. D.

May 14, 19 23 (Address) 1639 Bradley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cy

DATE OF BURIAL: May 14 1923

ADDRESS: William Bachrach 502 E Mulberry

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state age should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—3000 Itks.

D75723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 D75723

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Taylor

(Residence in Baltimore: No. 1802 McCulloh St.; 57 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ..., 1857
(Month) (Day) (Year)

7-AGE. 61 yrs. ..... mos. ..... da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 070
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Lollar

(Address) 1914 Int Royal Terr

15- Filed MAY 14 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 8th 1923, to May 13th 1923, that I saw h[illegible] alive on May 11th 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Abdominal Tumor

Uterus,

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Heart weakness

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) J. D. Talbert M. D.

5th, 1923 (Address) 211 N. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, January 15, 1923

20-UNDERTAKER Groseth & Holland ADDRESS 1631 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. If UNDER 1 YEAR, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75724
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

15 101 D75724

Registered No. C.....

City of BALTIMORE: (No. 1540 N. Bruce St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Robert Young .....

(Residence in Baltimore: No. 1540 N. Bruce St.; yrs. 57 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	widower

6-DATE OF BIRTH,
about 1866
(Month) (Day) (Year)

7-AGE,
57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE, (State or Country). Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, Noah Young

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, Mary

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Bruce

(Address) 1711 Pennsylvania Ave

15- MAY 14 1923
Filed ..... 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and, from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

May 12 1923. (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cemetery DATE OF BURIAL. 5/14/23

20-UNDERTAKER. J. Leon Hall ADDRESS 1724 McCulloh St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-20-21—E.B.R.S.—400 Blks.

D75725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75725

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2438 Rohland ave st., 7 Ward) 162

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Stanley

(a) Residence No. 2438 Rohland ave st., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 10 1923

7-AGE. ....yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Edgar Stanley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Ruth Beach

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant) Edgar Stanley

(Address) 2438 Rohland

15- Filed MAY 14 1923 192 ROBERT R. KRAUTER, Registrar. by Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 13 1923

17- I HEREBY CERTIFY, That I attended deceased from May 10 1923 to May 13 1923 that I last saw h[illegible] alive on May 13 1923 and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Asphyxia Neonatorum

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Lemmon M. D.

5/14/23 (Address) 718 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore	May 14 1923
20-UNDERTAKER.	**ADDRESS**
Wendell Diffendoon	378 Mm Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D75726

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4201 Elmora ave 26 ST., WARD)

2-FULL NAME Anna · M · Lutz

(a) RESIDENCE NO. 4201 Elmora ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife Late John Lutz

6 DATE OF BIRTH (month, day, and year) Dec. 4/1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Kunel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Lutz

(Address) 4201 Elmora ave

15 MAY 14 1923 ROBERT K. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1923, to May 11, 1923, that I last saw h[illegible] alive on May 11, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj. N. Henderson M. D.

5/14, 1923 (Address) 1216 N. Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery · DATE OF BURIAL: May 14 1923

20 UNDERTAKER: Geo. J. Ruth ADDRESS: 1735 Hayford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. NAME should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

(Nengel)

D75727

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-01 D75727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 E. Lafayette Ave. ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Nengel

(a) RESIDENCE No. 1307 E. Lafayette ave ST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry J. Nengel

6 DATE OF BIRTH (month, day and year) 4/19 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Ruth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant George A. Paul
(Address) 1307 E. Lafayette ave

Filed MAY 14 1923 HERBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17

I HEREBY CERTIFY, That I attended deceased from March, 1921, to May 10, 1923, that I last saw her alive on May 10, 1923, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Disease

(duration) 2 yrs. + mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert C. Knapp, M. D.

May 14, 1923 (Address) 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 14 1923
20 UNDERTAKER	ADDRESS
Geo. F. Ruth	1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE RESERVED FOR RECORD. DATE OF THIS CERTIFICATE should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Armwood

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

CERTIFICATE OF DEATH.

D75728

D75728

REGISTERED NO.

1-PLACE OF DEATH Baynew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST. 10 WARD)

2-FULL NAME Arthur Armwood

(a) RESIDENCE NO. 925 Sterling ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE Years 39. Months Days If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Baynew Hospital (Address) Balto. Md.

15 Filed MAY 14 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1923, to May 11, 1923

that I last saw h alive on May 10, 1923

and that death occurred, on the date stated above, at 1:15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of

Was there an autopsy? Yes + surgical

What test confirmed diagnosis? Clinical findings

(Signed) W. J. Goldsmith M. D.

5/11/1923 (Address) Baynew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL May 14 1923

20 UNDERTAKER John W Henderson — ADDRESS 1503 Edmonson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75729

CERTIFICATE OF DEATH.

74-001

D75729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Altona & Rosemary Ave. Hamilton 97 WARD)

2-FULL NAME William Strodthoff

(a) RESIDENCE NO. Altona & Rosemary aves WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhemina Strodthoff

6 DATE OF BIRTH (month, day, and year) May 26 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 916

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Albert K. Zimmerman

(Address) Altona & Rosemary aves

15 MAY 14 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2 1923, to May 12 1923, that I last saw h alive on May 12 1923 and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Simons, M. D.

5/13 1923 (Address) 4708 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	May 15 1923

20 UNDERTAKER ADDRESS

Wm C. Black 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75730

REGISTERED NO. D75730

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 W. Lanvale St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise H. Knierim

(a) RESIDENCE NO. 1813 W. Lanvale St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 ~~Single, Married, Widowed,~~ or ~~Divorced, (write~~ the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adam Knierim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helene J. Ruppert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Adam Knierim (Address) 1813 W. Lanvale St

15 Filed MAY 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 1923 to May 12 1923

that I last saw her alive on May 12 1923

and that death occurred, on the date stated above, at 4 30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Martin W Shook M. D.

5-12-23 (Address) 806 W Fayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: May 14 1923

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 217 S. Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. NAME AND RESIDENCE of INFORMANT is very important.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75731

REGISTERED NO. 129 D75731

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D75731
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 N. Monroe ST., 16 WARD)

2-FULL NAME John B. Wrightson

(a) RESIDENCE NO. 600 N. Monroe ST., 16 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jennie M. Wrightson

6 DATE OF BIRTH (month, day, and year) Oct 28. 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
62 yrs	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardware Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Retd

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Maryland

PARENTS

10 NAME OF FATHER John William Wrightson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md

12 MAIDEN NAME OF MOTHER Mary Jane Twyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co Md.

14 Informant Mrs. Jennie M. Wrightson
(Address) 600 N. Monroe St.

15 Filed MAY 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from April 12- 1923, to May 12- 1923, that I last saw him alive on May 12 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? auscultation

(Signed) Chester Riland-, M. D.

5-13 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenlawn Cemetery St. Mary's Co. Md.	May 14 1923
20 UNDERTAKER	ADDRESS
Jos Josselson & Son	215 S. Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75732

CERTIFICATE OF DEATH.

59-002

D75732

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Dover ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Not named (Infant Schuldt)

(a) RESIDENCE No. 1817 Dover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			Still Born 2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Karl Schuldt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amie Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Karl Schuldt

(Address) 1817 Dover St

15 Filed MAY 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 - 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11 - 1923, to May 12 - 1923, that I last saw h alive on May 12, 1923, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Failure of Innervation

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Stephen Dean, M. D.

, 19 (Address) 1817 Dover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemy	May 14 1923
20 UNDERTAKER MRS. M. S. FINK, FUNERAL DIRECTORS 1835 W. PRATT STREET	ADDRESS

N. B.—WRITE PLAINLY, WITH ONE ENDING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D75733

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... William G. Zachry.....

(Residence in Baltimore: No. West Point Ga. St.; yrs.,.....mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	S

6-DATE OF BIRTH. ..... Feb 6/1893 ....., 1..... (Month) (Day) (Year)

7-AGE. 30 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Georgia

PARENTS.

10-NAME OF FATHER. James T. Zachry

11-BIRTHPLACE OF FATHER, (State or Country). GA.

12-MAIDEN NAME OF MOTHER. Eppie H.

13-BIRTHPLACE OF MOTHER, (State or Country). Ga.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Griggs Zachry.....

(Address)..... West Point Ga.....

15- Filed MAY 14 1923 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May 13/23 ....., 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ...Inquiry..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) ...Inquiry... find that said deceased came to ...his... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide- pistol shot thru left nipple- cause of death pulmonary hemorrhage

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) J S H Talbot M. D. (Coroner.)

5/14/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Westpoint Ga	5/14/23
20-UNDERTAKER.	**ADDRESS**
J C Mitchell	1200 N Fayette St

D75734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75734

CERTIFICATE OF DEATH.

74-801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 N. Patterson Park Ave ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Elizabeth Smith

(a) RESIDENCE. No. 1321 N Patterson Park Ave ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Henry Smith

6 DATE OF BIRTH (month, day, and year) Oct 6 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
77	77	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Aaron Hertz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

11 Informant (Address) Alice B. Dorsey Daughter 164 N. Potomac St.

15 MAY 14 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 1922, to May 11 1923, (that I last saw her alive on May 11 1923, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) D. Herzog M. D. M. D.

May 12, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	5/14 1923
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75735

CERTIFICATE OF DEATH.

8 D75735

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Patterson Park Ave. 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur M. McClelland

(a) RESIDENCE. No. 228 N. Patterson Park Ave. 6th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olive M. McClelland

6 DATE OF BIRTH (month, day, and year) Oct. 1-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Isaac McClelland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Estella McKenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Olive M. McClelland (Address) 228 N. Pat. Pk. Ave

15 MAY 14 1923 ROBERT R. KRAUTER, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10 - 1923, to May 14, 1923, that I last saw him alive on May 14, 1923, and that death occurred, on the date stated above, at 2 50 a. m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Edwin B. Fenby M. D.

5/14/1923 (Address) 1223 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	May 14 1923
20 UNDERTAKER Philip Idenig	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75736

CERTIFICATE OF DEATH.

21 D75736

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 N Smallwood St.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah R Friedlander

(Residence in Baltimore: No. 172 N Smallwood St.; ....yrs. ....mos. 17 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, April (Month) 29 (Day), 1923 (Year)

7-AGE, ...yrs. ....mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Benjamin Friedlander

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Lena Friedlander

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ben Freidlander

(Address) 1708 N Smallwood St

15-

Filed ....., 191.. ROBERT R. KRAUTER Registrar.

MAY 14 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 13 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 11 1923, to May 13 1923, that I saw h[illegible] alive on May 13 1923, and that death occurred, on the date stated above, at 6:20 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) M. L. Kilman M. D.

5/13, 1923 (Address) 1515 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mehrem Hebrew Rem	May 14, 1923
20-UNDERTAKER	**ADDRESS**
Jack Lewis	1439 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75737

CERTIFICATE OF DEATH.

1 3 D75737

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 W. Fayette ST., 4 WARD)

2-FULL NAME John Bucher

(a) RESIDENCE NO. 705 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widr

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/12/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jno. Bucher

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Clara Cooper

13 BIRTHPLACE OF MOTHER (city or town) Ohio,
(State or country)

14 Informant John Bucher
(Address) 705 W. Fayette St.

15 MAY 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12/23 19

17

I HEREBY CERTIFY, That I attended deceased from 5/10/23, 19 , to 5/12/23 , 19 ,

that I last saw h— alive on 5/12/23 , 19 ,

and that death occurred, on the date stated above, at 6 45 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. History 2 wks. mos ds.

CONTRIBUTORY (Secondary) Inflation of Heart

(duration) yrs. History 2 wks mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No, Date of 5/3/23

Was there an autopsy? No.

What test confirmed diagnosis? Heart

(Signed) Bernard J. Stern, M. D.

5/12, 1923 (Address) Univ. Hosp. Dispensary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Cedar Hill Cemetery

DATE OF BURIAL
May 14 1923

20 UNDERTAKER
Margaret G. Flynn

ADDRESS
1422 Light St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75738 — 31 — D75738

CERTIFICATE OF DEATH

1-PLACE OF DEATH — CITY OF BALTIMORE: (No. Cross Country & North Ave ST.; 27 WARD) — REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick D. Reinhimer

(Residence in Baltimore: No. Cross Country Blvds. & north ave St.; 68 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male — 4-COLOR OR RACE: White — 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, April (Month) 7 (Day) 1870 (Year)

7-AGE, 68 yrs. 1 mos. 1 ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frederick Reinhimer

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Catherine Miller

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Reinhimer

(Address) Cross Country & North Ave

15- MAY 14 1923 191... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1922, to May 10 1923, that I saw h[illegible] alive on May 10 1923, and that death occurred, on the date stated above, at 11.20 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis — Glands of Lungs

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ✓

(Duration) yrs. mos. ds.

(Signed) Chas F Blake M. D.

May 10, 1923 (Address) 20 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Olivet Cem. — DATE OF BURIAL. 5/13/..., 1923

20-UNDERTAKER Margaret E. Flynn — ADDRESS 111 Light St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75739

CERTIFICATE OF DEATH.

162 D75739

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 W Saratoga ST., 18 WARD)

2-FULL NAME Child of Wm + Mamie Owings

(a) RESIDENCE NO. 936 W Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/11/23

7 AGE — Years — Months — Days

If LESS than 1 day 16 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Wm. A. Owings

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mamie Jackson

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Wm A Owings
(Address) 936 W Saratoga

15 Filed MAY 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/11, 1923, to 5/14, 1923, that I last saw him alive on 5/14, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. T. Howell M. D.

5/13/ 1923 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: May 14 1923

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75740

CERTIFICATE OF DEATH.

1924 D75740

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 248 S. Fifth ST., 7th WARD)

2-FULL NAME Andreas Kronert

(a) RESIDENCE NO. 248 S. Fifth ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Kronert

6 DATE OF BIRTH (month, day, and year) Dec. 13, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Andreas Kronert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Theuter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Marie Kronert

(Address) 248 S. Fifth St.

15 Filed MAY 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from May. 6, 1923, to May. 13, 1923,

that I last saw h[illegible] alive on May. 12, 1923,

and that death occurred, on the date stated above, at 8 1/4 a.m.

The CAUSE OF DEATH* was as follows:

—Heart insufficiency.

(duration) x yrs. x mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. X mos X ds.

18 Where was disease contracted if not at place of death? Same.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Same.

(Signed) Jas L. Dwyer, M. D.

11/24/23 (Address) 248 S. 20 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz — DATE OF BURIAL May 15 1923

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75741

CERTIFICATE OF DEATH.

14-001

D75741

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Duffy

(a) RESIDENCE No. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed MAY 14 1923 19 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1921, to May 11, 1923, that I last saw him alive on May 10, 1923, and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Residual hemiplegia

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. A. McKay, M. D.

5-12-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 5/14 1923

20 UNDERTAKER Thos. M. Fink

ADDRESS 1737 E. Fallon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

D75742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75742

1-PLACE OF DEATH University Hospital

REGISTERED NO. 57

CITY OF BALTIMORE: (No. ..... St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. J. McGraw

(a) RESIDENCE No. 2525 E. Madison St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa McGraw

6 DATE OF BIRTH (month, day, and year) Dec 26. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James McGraw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McKenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward J. McGraw

(Address) 2304 McElderry Ave

15 MAY 14 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/13, 1923, to 5/13, 1923, that I last saw him alive on 5/13, 1923, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) [redacted]

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Anthony V. Bucciarelli, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL May 14 1923

20 UNDERTAKER John O. Mitchell

ADDRESS 1201 N. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D75743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D75743

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. President Hop St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Carra Sutton

(Residence in Baltimore: No. 11 E. W. Biddle St. St.; yrs. 20 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	colored	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1..87 (Year)

7-AGE.	If LESS than 1 day,
46 yrs. ..... mos. ..... ds.	....hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country). N. C.

PARENTS.

10-NAME OF FATHER, Israel Sutton

11-BIRTHPLACE OF FATHER, (State or Country). N. C.

12-MAIDEN NAME OF MOTHER, Hester Daft

13-BIRTHPLACE OF MOTHER, (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ida Lincoln

(Address) Fredericksburg Va.

15- MAY 14 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 10 (Day) 192[illegible] (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Chronic Endocarditis

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

May 1 192[illegible] (Address) [illegible]

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Mt Auburn Cem 5/14/23

20-UNDERTAKER. ADDRESS.

Samuel S Hensley 1128 Mt

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75744 (Clifford) CERTIFICATE OF DEATH. 31 D75744

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N Schroeder ST., 18 WARD)

2-FULL NAME Clifford Brown

(a) RESIDENCE NO. 314 N Schroeder ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None.

6 DATE OF BIRTH (month, day, and year): July 13 1894

7 AGE: Years 28 Months 8 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 10

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md Dale

PARENTS

10 NAME OF FATHER: Thomas R Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hannah Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Marie Carter

(Address): 314 N Schroeder

15 FILED MAY 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl 13 1923, to May 11 1923, that I last saw h[illegible] alive on May 10 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

May 11, 1923 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 5/14 1923

20 UNDERTAKER: Samuel Wesley

ADDRESS: W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75745

CERTIFICATE OF DEATH.

1929 D75745

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 W. Lee ST., 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene William Woods

(a) RESIDENCE NO. 534 W. Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma V. Woods

6 DATE OF BIRTH (month, day, and year) Apr. 29, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver - Wagon 023

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Charlottesville
(State or country) Virginia

PARENTS

10 NAME OF FATHER Elijah Woods

11 BIRTHPLACE OF FATHER (city or town) Charlottesville
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Charlotte Shelton

13 BIRTHPLACE OF MOTHER (city or town) Charlottesville
(State or country) Virginia

14 Informant Henrietta F. Todd
(Address) 534 W. Lee St.

15 MAY 14 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 2, 1923, to May, 11, 1923.

that I last saw he alive on May, 10, 1923.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis — Chr. Interstitial Nephritis (duration) yrs. (unknown) mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no, Date of

Was there an autopsy? no,

What test confirmed diagnosis? Urine —

(Signed) David Drawdin M. D.

5/17 1923 (Address) 122 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	May 14, 1923
20 UNDERTAKER	ADDRESS
Samuel Hensley	Baltimore

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75746 ✓ 101-001 D75746

D75746
1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 671 Bradley ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Jackson

(a) RESIDENCE. No. 671 Bradley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Jackson

6 DATE OF BIRTH (month, day, and year) June 8, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Club

(c) Name of employer Maryland Club Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza F. Francis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs Sarah Jackson (Address) 671 Bradley St

15 MAY 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1923, to May 13, 1923 that I last saw h[illegible] alive on May 13, 1923 and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs, symptoms

(Signed) John E. L. Gaupher, M. D.

, 19 (Address) 1402 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 5/16/23

20 UNDERTAKER: Samuel Kemsley — ADDRESS: Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D75747

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johnsons of America Hospital ST.: 19 WARD)

2-FULL NAME Miss Annie E Jefferis

(a) RESIDENCE. No. 1543 Ramsay St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 7 mos. 4 ds. How long in U. S., If of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8 1838

7 AGE — Years: 84 — Months: 7 — Days: 4 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William Y. Jefferis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Ann Eliza Diamond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Miss Elizabeth Robinson

(Address) 2223 Callow ave

15 Filed MAY 14 1923 19.... ROBERT R. KRANTZ Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1923, to May 12th, 1923, that I last saw her alive on May 12th, 1923, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.
Chronic Interstitial Nephritis.

.....(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo E Wells, M. D.

, 19 (Address) 1521 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	5/15/23
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. Fayette ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Irvin H Fisher

D75748

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D75748

Registered No.....

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ~~1921 Oak Hill Ave~~ ..... 9 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Irvin H. Fisher

(a) Residence No. 1921 Oak Hill Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 31, 1887

7-AGE. 40 yrs. 9 mos. 17 ds.

If LESS than 1 day ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... New York

(State or Country),

PARENTS.

10-NAME OF FATHER, Simon Fisher

11-BIRTHPLACE OF FATHER (city or town) Germany

(State or Country),

12-MAIDEN NAME OF MOTHER, Eva Newman

13-BIRTHPLACE OF MOTHER (city or town) Germany

(State or Country),

14- (Informant) C. Uelfeld

(Address) 1921 Oak Hill Ave

15- Filed MAY 14 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/12/23

17- I HEREBY CERTIFY, That I attended deceased from April 27 1923 to May 12, 1923 that I last saw h. ~~native~~ on May 12 1923 and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia Cardiac Failure

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/30/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Daniel J Flanagan M. D.

5/20, 1923 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Hebrew Friendship	5/14/1923
20-UNDERTAKER,	ADDRESS
David Sondheim	118-20 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75749

CERTIFICATE OF DEATH.

164 D75749

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Ruxton St. Lbx 15 WARD)

2-FULL NAME Mat Treuman

(a) RESIDENCE No. 1723 Ruxton Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Treuman

6 DATE OF BIRTH (month, day, and year): Dec. 2, 1837

7 AGE — Years: 85 — Months: 5 — Days: 10 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ret. Furniture

(b) General nature of industry, business, or establishment in which employed (or employer): Dealer 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Samuel Treuman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss R. Goodman
(Address): 1723 Ruxton Ave

15 MAY 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/12/1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to May 12, 1923, that I last saw him alive on May 12, 1923, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred C Jewett M. D.

19 (Address) 2516 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship C

DATE OF BURIAL: 5/15/1923

20 UNDERTAKER: David Sondheim

ADDRESS: 115 N. Mt. Royal Ave

Spec. 6-3-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75750 CERTIFICATE OF DEATH. 159-002 D75750

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Goode

(a) RESIDENCE. NO. St. Elizabeth's Home Chestnut Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER - - - - Barnes

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Jaquetta Goode

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 MAY 14 1923 ROBERT R. KRAUTER, Registrar
Asst. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to May 9, 1923, that I last saw him alive on May 9, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

May 10, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND,	19
20 UNDERTAKER	ADDRESS
Commissioner Health, per Wm. E. Woodall.	MAY 12 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94 D75751

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 S. Linwood ave St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene M. Barlow

(a) Residence No. 707 S. Linwood ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 19-1922

7-AGE. 1 yrs. 1 mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry A. Barlow

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md

12-MAIDEN NAME OF MOTHER, Dora Taylor

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Henry A. Barlow

(Address) 707 S. Linwood ave

15- Filed MAY 14 1923 ROBERT R. KRAUTER Asst. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 5 19 23 to May 12 19 23

that I last saw h[illegible] alive on May 11 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Angina

Toxic Endocarditis

Endocarditis

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Tonsilitis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Signs

(Signed) Daniel F. Foster, M. D

, 19 (Address) 332 S. Ann St. City

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. First German Evangelical

DATE OF BURIAL. May 14 1923

20-UNDERTAKER. Jos. C. Miller

ADDRESS 2334 Jefferson st.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D75752

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 W 25 ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph [illegible] Spruceback

(a) RESIDENCE NO. 402 W 25 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	1	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Howard Spruceback

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Phila Winkler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant Howard Spruceback (Address) 402 W 25 St

15 MAY 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to May 12, 1923, that I last saw him alive on May 12, 1923, and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Spinal Fluid

(Signed) [illegible] M. D.

, 19 (Address) 2439 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 15 1923

20 UNDERTAKER ADDRESS

Chenowith & Son Chestnut

Spec.—1-10-21—M&T—1500 lbs.

1933
1896
3
D75753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D75753

REGISTERED NO.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 N Balto ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Schreck.

(a) RESIDENCE No. 2233 N Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Schreck.

6 DATE OF BIRTH (month, day and year) Nov 9 1848

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	3	4	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Schreck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Eschenbach.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary F. Schreck.
(Address) 2233 N Balto St

15 Filed MAY 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11. 1923, to May 13. 1923.

that I last saw living on May 13. 1923

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

a Apoplexy.

(duration) yrs. mos 3. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure Urinary

(Signed) Edgar E Travers M. D.

(Address) 1520 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 5-16 1923

20 UNDERTAKER E B Hale — ADDRESS 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75754

CERTIFICATE OF DEATH. 125-00

D75754

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 N. Bruce ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Burke, Jr.

(a) RESIDENCE. NO. 1308 N. Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1922

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. Burke Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Stella Briscoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Stella Burke (Address) 1308 N. Bruce St.

15 Filed MAY 14 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923 to May 12, 1923, that I last saw him alive on May 12, 1923, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions
(Cause unknown)
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chicken-pox.
(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Quinn M. D.

5/13/23 (Address) 1507 N. Dutton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel, Tenn.	May 14 1923

20 UNDERTAKER James B. Lewis ADDRESS 1302 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D75755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2464 Bruce St., 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willis Reed

(Residence in Baltimore: No. 2464 Bruce St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word)
Male	Colored	Single

6-DATE OF BIRTH. Jan (Month) 11 (Day) 1923 (Year)

7-AGE. ....yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balt md

PARENTS

10-NAME OF FATHER. Willis Reed

11-BIRTHPLACE OF FATHER, (State or Country). Norfolk Co Va

12-MAIDEN NAME OF MOTHER. Eugenia Jones

13-BIRTHPLACE OF MOTHER, (State or Country). Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willis Reed

(Address) 2464 Bruce

15- Filed MAY 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 13 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH*, was as follows:

Whooping Cough

(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) died during Cough Spasm (Duration) ....yrs. ....mos. ....ds.

(Signed) Jno. Emmett Gardner M. D.
(Coroner)

May 14 1923 (Address) 703 Eutaw St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem DATE OF BURIAL. 5/15 1923

20-UNDERTAKER. Albert H. Leuthauser ADDRESS 1313

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75756

CERTIFICATE OF DEATH.

154-002

D75756

REGISTERED NO.

1-PLACE OF DEATH St. V. Supt Asy.

CITY OF BALTIMORE: (No. 1401 division ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Martin Dunn

(a) RESIDENCE NO. 1301 Hillman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15-1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... (none)

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Richard Dunn

(Address) 1301 Hillman St.

15 MAY 14 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1923

17

I HEREBY CERTIFY, That I attended deceased from March 14 1923, to May 13, 1923,

that I last saw her alive on May 12, 1923,

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Chas. L. Goldborough Jr. M. D.

19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 14 1923

UNDERTAKER H. C. Wiedefeld

ADDRESS 914 Greenmount Ave

Spec.—1-10-21—M&T—1500 Bks.

D75757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75757

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 S. Paca ST. 71 WARD)

2-FULL NAME Anna M. Daly

(a) RESIDENCE NO. 932 S. Paca ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Timothy Goonan

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Goniff

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Aileen Pollard
(Address) 932 S. Paca st

15 Filed ..... 19..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to May 12, 1923, that I last saw h... alive on ....., 19....., and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ~ yrs. 5 mos. ~ ds.

CONTRIBUTORY (Secondary) Gangrene of Both feet

(duration) — yrs. 1 mos. ~ ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Edw. Gorman M. D.

5/13. 1923 (Address) 517 Leadenhall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 15 1923.
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca st

MAY 14 1923

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Elterman

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75758

CERTIFICATE OF DEATH.

99-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Frederick ave ST. 70 WARD)

2-FULL NAME Hermann Eltermann

(a) RESIDENCE. NO. 1303 Frederick ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Eltermann

6 DATE OF BIRTH (month, day, and year) March 13. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bertha Eltermann
(Address) 1303 Fredk: Ave:

15 MAY 14 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14 1923 to May 12 1923, that I last saw her alive on May 11 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Egnatar Dill M. D.

5/14. 1923 (Address) 1453 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 15, 1923
20 UNDERTAKER E. W. Dill	ADDRESS 3109 Fredk: Ave:

E.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D75759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75759

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 610 So. Broadway St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Zeller

(Residence in Baltimore: No. 322 So. Chapel st St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Jan 15th 1860 (Month) (Day) (Year)

7-AGE 63 yrs. 3 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Peter Lepper

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Strearn

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Zeller

(Address) 322 So. Chapel St

15. MAY 14 1923

Robert P. Harrison,

1923 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, au- (Inquest, Autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) about one ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. B. Horton M. D.

May 13 1923 (Address) Curtis Bay Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. Cerebral Hem.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Salisbury Cemetery DATE OF BURIAL, May 14th 1923

20-UNDERTAKER, Lilly & Zeiler ADDRESS 403 S. Wolfe St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D75760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75760

CERTIFICATE OF DEATH.

60-602

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST. 16 WARD)

2-FULL NAME Cecilia Strechfuss

(a) RESIDENCE NO. 804 N. Collington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 15-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Leonard Strechfuss

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Margt. Kaufrane

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Edward J. Strechfuss
(Address) Elkton Md

15 Filed ..... 1923 ..... 19 ..... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to May 13, 1923, that I last saw her alive on May 13, 1923, and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Toxic Goitre.

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insuffi. (duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-9-23

Was there an autopsy? Not

What test confirmed diagnosis? Symptoms & P.S.

(Signed) J. V. Szlabicki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 5/16 1923

20 UNDERTAKER Tilly & Stiles — ADDRESS 403 N Howard

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 14 1923

Spec.—1-10-21—M&T—1500 Bks.

D75761 D75761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home + Infirmary 6

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary R. Hobbs.

(a) RESIDENCE NO. 105 N. Luzerne Ave City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 3 mos. ds. How long in U. S., If of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos A. Hobbs

6 DATE OF BIRTH (month, day, and year) Jan 21/1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Shaw

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Williams

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mary R. Hobbs
(Address) 105 N. Luzerne ave.

MY 14 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1923, to May 12, 1923, that I last saw her alive on May 12, 1923 and that death occurred, on the date stated above, at 11.50 P m

The CAUSE OF DEATH* was as follows:

Brain Tumor - Rt. Temporal

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of April 7 1923 April 25 '23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) H. C. Rice, M. D.

, 19 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	May 16 '23

20 UNDERTAKER Jos. J. Iden ADDRESS 1564 Luzerne Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form—12-23-21—E.P.F.S.—400 Pks.

D75762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75762

CERTIFICATE OF DEATH.

Registered No. 2161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Swales (Jeserun)

(a) Residence No. 410 Seibt St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 5-14-23

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 33 hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Mary Land

PARENTS.

10-NAME OF FATHER, John Swales

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Louisa Swales

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant)

(Address) JOHNS

15- Filed ... Robert P. Harrison, Registrar.

MAY 14 1923 Burial Permit Clerk. 0373

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-14-23

17- I HEREBY CERTIFY, That I attended deceased from 5-13, 1923, to 5-14, 1923

that I last saw h[illegible] alive on 5-14, 1923

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam of Signs

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER.

ADDRESS

Commissioner Health,

Per. Wm. E. WOODALL

MAY 14 1923

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stat.—12-23-21—E.B.R.S.—400 lks.

D75763

HEALTH DEPARTMENT---CITY OF BALTIMORE

D75763

CERTIFICATE OF DEATH.

161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Sivolella (Josephine)

(a) Residence No. 410 Exeter St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 5-13-23

7-AGE. ....yrs....mos....ds. If LESS than 1 day, 12 hrs. 30 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Sivolella.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Santina Fabella

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant)

(Address) JOHNS HOPKINS HOSPITAL

15- Robert P. Harrison,

Filed ..... 192.... Registrar.

MAY 14 1923 Burial Permit Clerk

0578

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-13-23.

17- I HEREBY CERTIFY, That I attended deceased from 5-13 1923 to 5-13 1923

that I last saw h. alive on 5-13 1923

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) D. J. Greenough M. D.

, 19 (Address) Med. Dept.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER

ADDRESS

Commissioner Health.

Per. Wm. S. WOODALL.

MAY 14 1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75764

160 908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75764

CERTIFICATE OF DEATH

58-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Jones

(a) RESIDENCE NO. Kitzmiller, Md. ST., WARD. Kitzmiller Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Ida D.

6 DATE OF BIRTH (month, day, and year) August 23, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Mary Kern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 JOHNS HOPKINS HOSPITAL.
Informant
(Address)

15 Filed MAY 14 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17

I HEREBY CERTIFY, That I attended deceased from January 4. 1923. to May 14. 1923.

that I last saw him alive on May 14. 1923.

and that death occurred, on the date stated above, at 9.20 A.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas R Bugg M.D.

19 (Address) JOHNS HOPKINS HOSPITAL.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Blaine W. Va — DATE OF BURIAL: May 14 1923

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 B. Way

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75765 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75765

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Bay View St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward C. Caskey

(Residence in Baltimore: No. Bay View St.; 30 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Apr 22 1888
(Month) (Day) (Year)

7-AGE 35 yrs. ... mos. 7 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country). W. Va

PARENTS.

10-NAME OF FATHER, James E. Caskey

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER, Mary Fox

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) V. W. Caskey Brooklyn Md

(Address) 914 Frederick St.

15- May 14 192 3 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

4 years

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Edema Lungs

(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm. B. Norton M. D.
Coroner

May 14 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Endocard.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Loudon Park May 15 1923

20-UNDERTAKER. ADDRESS

Wm Cook 002 E. Lee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75766 HEALTH DEPARTMENT—CITY OF BALTIMORE D75766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. 525 So. Caroline St., 3 Ward) Registered No. C. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Ludwig

(Residence in Baltimore: No. 525 So. Caroline St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: About 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) Eastern Dist

15- Robert F. Garrison, Registrar.

1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest as (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
Coroner.

May 14 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: May 15 1923

26-UNDERTAKER: Lichy and Zeiler ADDRESS: 402 S. Wolfe St.

Spec.—8-24-14—M. & T.—2000 Bks.

D75767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002 D75767

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. H. Mary Industrial Sch. St. 75 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Shilling

(Residence in Baltimore: No. H. Mary Industrial School St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 31, 1907 (Month) (Day) (Year)

7-AGE, 15 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Chas J Shilling

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Emma Doppler

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Shilling

(Address) 1619 Washington

15- Filed MAY 14 1923 Robert F. Harrison, Burial Permit Clerk, Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1923, to May 13 1923, that I saw h[illegible] alive on May 12 1923, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

..... (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Infected Tonsils

..... (Duration) yrs. 4 mos. ds.

(Signed) J. T. Clemens M. D.

5/17, 1923 (Address) 804 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dby Cedar Hill DATE OF BURIAL, 5/16, 1923

20-UNDERTAKER Frank Smith ADDRESS Talbot Laylette

Dup.—12-23-21—E.B.R.S.—400 Blks.

D75768 HEALTH DEPARTMENT—CITY OF BALTIMORE D75768

CERTIFICATE OF DEATH. X 4 44

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. W. Jerry Jones.

(a) Residence No. Delta, Penna. St., Ward Delta Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs. Wm Jerry Jones

6-DATE OF BIRTH (month, day and year) Dec 5th 1857

7-AGE. 66 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Stationary Operator.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Penna.

PARENTS.

10-NAME OF FATHER. David Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Penna.

12-MAIDEN NAME OF MOTHER. Mary Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Penna.

11- (Informant) Hospt Record

(Address)

15. ROBERT E. GRIFFITH

19.. Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14 23

17- I HEREBY CERTIFY, That I attended deceased from April 30 1923 to May 14 1923

That I last saw h.. alive on May 13 1923

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH was as follows:

Pneumonia

Sepsis.

(Duration) yrs. 6/12 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis.

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Septic Hospital

Did an operation precede death? Yes Date of 5-8-23

Was there an autopsy? No.

What test confirmed diagnosis? Pure Sepsis, + Spec. Pneumococcus

(Signed) L. J. Steagle M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Delta Pa. DATE OF BURIAL. 5/16/23

20-UNDERTAKER. Earl Finley Talbot ADDRESS Fayette

DEC 1 1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Deliver)

D75769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75769

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Jewish Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Marie Dreker

(Residence in Baltimore: No. 712 W. Lexington St. St.; yrs. 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Femal	White	Sgle

6-DATE OF BIRTH. Feb (Month) 26 (Day) 1923 (Year)

7-AGE. ....yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... L
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Bad City

PARENTS.

10-NAME OF FATHER. John A Dreker

11-BIRTHPLACE OF FATHER, (State or Country). Bad City

12-MAIDEN NAME OF MOTHER. Mary V. Christy

13-BIRTHPLACE OF MOTHER, (State or Country). Bath City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A Dreker

(Address) 712 W Lexington St

15- Robert P. Harrison,

Filed 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 13 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Skull, Fgt. from Motors Arms Ld Patrimut

(Duration) ....yrs. ....mos. a few hours ds.

CONTRIBUTORY (Secondary) Mother fell carrying child in arms'

(Duration) ....yrs. ....mos. ....ds.

(Signed) H K Jamison M. D. (Coroner.)

6-14 1923 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St. Marys (Hampden) DATE OF BURIAL. May 15 1923

20-UNDERTAKER Horace M. Burgee ADDRESS 363 Falls Road

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

14 1923

D75770 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75770

CERTIFICATE OF DEATH. 15 168

1-PLACE OF DEATH

City of BALTIMORE: (No. 2506 Chelsea Terrace Ward) 15

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elizabeth L Ligon

(Residence in Baltimore: No. 2506 Chelsea Terrace St.; yrs. 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Sept (Month) 18 (Day) 1842 (Year)

7-AGE. 30 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Geo. D. Haines

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Maria W. Conner

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P J Ligon

(Address) 4313 Fortest Park Av

15- Robert F. Harrison, 192 Registrar.

Burial Permit Clerk.

MAY 14 1923

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 13 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Kennedy M. D. (Coroner.)

May 14, 1923 (Address) 2502 Edmondson Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Richmond Va	May 15 1923
20-UNDERTAKER. W. H. Mackenzie Sons	ADDRESS North & Pa

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75771 ✓ D75771

CERTIFICATE OF DEATH. X139

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Ave ST. 12 WARD)

2-FULL NAME Jennie V. Chenoweth

(a) RESIDENCE NO. Catonsville Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

R.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state
E should be stated EXACTLY. AGE should be carefully supplied. AGE, sho
it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly
on back of certificates.
TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Chenoweth

6 DATE OF BIRTH (month, day, and year) June 14, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER David Carbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Maria King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant John C. Chenoweth
(Address) Catonsville Md

15 Robert F. Harrison, Registrar
MAY 14 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1923, to May 13th, 1923, that I last saw her alive on May 12th, 1923, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Myomata of uterus

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage after Hysterectomy (duration) — yrs. — mos. One ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 9, 1923

Was there an autopsy? No

What test confirmed diagnosis? diagnosis confirmed at operation

(Signed) Stiehm F. Stiehman, M. D.

, 19 (Address) 66 Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL 19

20 UNDERTAKER Wm J Tickner & Son — ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Blks.

D75772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 N Monroe ST., 15 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kremer - Jr -

(a) RESIDENCE NO. 1908 Kremer ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr - 25-1921

7 AGE — Years: 1 — Months: 4 — Days: 18 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER Thomas Kremer

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER Mildred Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Thomas Kremer
(Address) 1908 N Monroe

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 - 1923, to May 13 - 1923, that I last saw he alive on May 13 1923, and that death occurred, on the date stated above, at 7.20 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Measles

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Lee Brooks M. D.

, 19 (Address) 1348 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: May 14, 23

20 UNDERTAKER: W L Tickmeyer Sons — ADDRESS: Walbrook

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be given in all cases, whether over or under one year. Any information that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75773

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75773

CERTIFICATE OF DEATH.

99-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3428 Edmonson St., 16 WARD)

2-FULL NAME Mary E. Vahle

(a) RESIDENCE No. 3428 Edmonson Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Vahle

6 DATE OF BIRTH (month, day, and year) Mar 27-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	77	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bet. city and (State or country)

PARENTS

10 NAME OF FATHER Aug G Becker.

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Elz Schumacher

13 BIRTHPLACE OF MOTHER (city or town) Md. City (State or country)

14 Informant Chas Vahle (Address) 3428 Edmonson Ave

15 Filed 14 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1923, to May 13 1923.

that I last saw h.. alive on May 12 1923,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Emanuel, M. D.

5/14 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 15 23

20 UNDERTAKER W. J. Tuckwell Sons — ADDRESS North

N. B.—WRITE PLAINLY, WITH PEN AND INK. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ONSET and DURATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1600 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75774

CERTIFICATE OF DEATH.

90

D75774

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 N. Carey St.: 18 Ward)

2-FULL NAME Lillian W. Caldwell

(a) RESIDENCE. No. 107 N. Carey St., Ward,
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Fuller M. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Clarence G. Beardmore
(Address) Annapolis Md.

15 Filed MAY 14 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1923, to May 9, 1923, that I last saw her alive on May 9, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchmers, M. D.

, 19 (Address) 650 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md

DATE OF BURIAL 5-16-19

20 UNDERTAKER Geo. J. Smith

ADDRESS 1524 Hollins St

CAUSE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75775

CERTIFICATE OF DEATH.

31

D75775

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zachriah T. Legoe

(a) RESIDENCE NO. 4403 E. Lombard st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) Sept 16, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 60

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lake Legoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records M.T.H.

15 MAY 16 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1923, to May 13, 1923, that I last saw him alive on May 15, 1923, and that death occurred, on the date stated above, at 12 midnight

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) Francis L. Pasaglucca M. D.

5-14-23 (Address) Municipal Tuc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. M. Clinchy	May 16 1923
20 UNDERTAKER	ADDRESS
William Cook	502 E. Fayette

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—R.H.R.S.—400 Blks.

D75776 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D75776

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 129

City of BALTIMORE: (No. 809 S. Ann St., 1 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katharine Friedel

(a) Residence No. 809 S. Ann St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F | 4-COLOR OR RACE, W | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Conrad Friedel

6-DATE OF BIRTH (month, day and year) Jan 6 1854

7-AGE. 69 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Home
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.
10-NAME OF FATHER. Bernard Seeang
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany
12-MAIDEN NAME OF MOTHER. Margaret Hahn
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs Fannie Wolfe
(Address) 37 So 1 Ave E

15- Filed Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 13 1923

17. (I HEREBY CERTIFY, That I attended deceased from April 12 1923, to May 13 1923, that I last saw her alive on May 13 1923, and that death occurred, on the date stated above, at 3-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. C. Keen, M. D.

5/14/23 (Address) 408 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Paul's | DATE OF BURIAL, May 16, 1923

20-UNDERTAKER. Wm Cook | ADDRESS 502 E Fayette

Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75777

CERTIFICATE OF DEATH.

94

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 708 S. Montford St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kleismith

(a) Residence No. 708 S. Montford ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) X

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 9- 1922

7-AGE. ....yrs. 8 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michael Kleismith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Agnes Szymanski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

11- (Informant) Michael Kleismith

(Address) 708 Montford ave

15- Filed MAY 14 1923 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 13/ 23

17- I HEREBY CERTIFY, That I attended deceased from May 5 1923 to May 13 1923 that I last saw him alive on May 12 1923 and that death occurred, on the date stated above, at 11.10 p.m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Influenza Tonsilitis

Throat (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Presumptive

(Signed) Manuel Brown M. D

, 19 (Address) 332 S Paca st

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Stanislaus

DATE OF BURIAL, May 15, 1923

20-UNDERTAKER, I am maseby

ADDRESS 1803 Bank st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 14 1923

Spec.—1-10-21—M&T—1500 Blks.

D75778

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D75778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Wildberger

(a) RESIDENCE NO. 118 S. Callender ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 15-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER [redacted] W. Charles

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Hankey

13 BIRTHPLACE OF MOTHER (city or town) Hagers Burg (State or country) W. Va.

14 Informant [redacted] Early Sister W. Wildberger

(Address) 118 S. Callender.

Filed MAY 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17

I HEREBY CERTIFY, That I attended deceased from April, 1923, to May 15, 1923, that I last saw h[illegible] alive on May 15, 1923, and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Dorothy V. Bradley, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery Reisterstown Md.

DATE OF BURIAL May 16, 1923

20 UNDERTAKER Henry Hoeck Son

ADDRESS 1502 E Eager St.

N. B.—WRITE PLAINLY WITH LEAD PENCIL. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75779

CERTIFICATE OF DEATH.

31 ✓ D75779

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 636 Bradley St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Abahan Bowie

(Residence in Baltimore: No. 636 Bradley St. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	widower

6-DATE OF BIRTH. about 1873
(Month) (Day) (Year)

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Porter
(b) General nature of industry, business, or establishment in which employed (or employer). Hotel

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. [illegible]

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Bowie

(Address) 636 Bradley St.

15- FILED MAY 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 12 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chas. Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) D. T. Hennessy M. D.
Coroner.)

May 14 1923. (Address) 218 Courtland St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	May 15, 1923
20-UNDERTAKER.	ADDRESS
Mrs. Kate R. Williams	322 N. Schroeder St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If UNKNOWN state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 12-23-21 - F.P.F.S. - 400 Pds.

D75780

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 ✓

D75780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester Jackson

(a) Residence No. 718 Stockston St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1870

7-AGE.	If LESS than 1 day.
52 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Chestertown, Md.

PARENTS.

10-NAME OF FATHER, Anna B. Perry

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Eastern Shore, Md.

12-MAIDEN NAME OF MOTHER, Levin Perry

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Eastern Shore, Md.

11- (Informant) Municipal Hospital Records

(Address)

15- MAY 15 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 29, 1923 to May 12, 1923

that I last saw her alive on May 11, 1923

and that death occurred, on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. A. McKay, M. D

5-12-1923 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Auburn Cemetery	May 15, 1923
20-UNDERTAKER.	ADDRESS
Mrs. Katie R. Williams	322 N. Schroeder St

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75781

CERTIFICATE OF DEATH.

9 D75781

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 333 N. Bruce ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Franklin

(a) RESIDENCE NO. 333 N. Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	11	9 days.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Franklin

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Foster

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Edward Franklin (Address) 333 N. Bruce St.

15 FILED MAY 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923.

17. I HEREBY CERTIFY, That I attended deceased from May 8 , 1923 , to May 14 , 1923 , that I last saw her alive on May 13 , 1923 ; and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) Whooping Cough.

(duration) — yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? auscultation & percussion

(Signed) Chester Riland, M. D.

5-14-1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	May 17 1923
20 UNDERTAKER James N. Dennis	ADDRESS 303 Cumberland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75782

CERTIFICATE OF DEATH.

1887 35 57 D75782

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 E Clement ST. 24 WARD)

2-FULL NAME Oda. Vogelgesang,

(a) RESIDENCE NO. 423 E Clement ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. H Vogelgesang

6 DATE OF BIRTH (month, day, and year) Oct 28 1862

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John. H. Vogelgesang
(Address) 423 E Clement St.

15 Filed MAY 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1923, to May 12, 1923, that I last saw h... alive on May 12, 1923 and that death occurred, on the date stated above, at 11 38 A m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

May 15, 1923 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 5-15-1923

20 UNDERTAKER E & B Hahn — ADDRESS 115 E West St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75783

CERTIFICATE OF DEATH.

100-001

D75783

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S Collington ave WARD)

2-FULL NAME Andrew H Turner

(a) RESIDENCE NO. 231 S Collington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Liddia P Turner

6 DATE OF BIRTH (month, day, and year): May 19 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Haven Conn

PARENTS

10 NAME OF FATHER: John Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Haven Conn

12 MAIDEN NAME OF MOTHER: Mary Holt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Haven Conn

14 Informant: Liddia P Turner

(Address): 231 S Collington ave

15 Filed MAY 15 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1923

17 I HEREBY CERTIFY, That I attended deceased from May 13 1923 to May 14 1923.

that I last saw h— alive on May 14 1923.

and that death occurred, on the date stated above, at 12-05 a m.

The CAUSE OF DEATH* was as follows: Senile - Marasmus - Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): contrib failure

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) [illegible], M. D.

, 19 (Address) 125 W Pdon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetry

DATE OF BURIAL: May 16 1923.

20 UNDERTAKER: Robt F Turner Inc

ADDRESS 1442 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16780

D75784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 ✓ D75784

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Albert E Clay

(a) RESIDENCE NO. Tucumcari. New Mexico ST., WARD D
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. 4 How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucille Clay

6 DATE OF BIRTH (month, day, and year) Jan 26 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman, railroad

(b) General nature of Industry, business, or establishment in which employed (or employer) Sante Fe R.R. 173

(c) Name of employer Sante Fe R R. 173

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Minor D Clay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Susan McBaes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant (Address) Texarkana

Filed MAY 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1923

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1923, to May 11, 1923, that I last saw him alive on May 11, 1923 and that death occurred, on the date stated above, at 6 35 P.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor. left occipital dural endothelioma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post-operative meningitis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of May 2

Was there an autopsy? Hefad. yes

What test confirmed diagnosis? Operation

(Signed) J.C. Reichert, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: East Las Vegas New Mex

DATE OF BURIAL: 5/16 1923

20 UNDERTAKER: I. Fero McCalby

ADDRESS: 130 E. Fort

N.B.—WRITE plainly and carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may b TION is very important. See instructions on back o

Size—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75785

CERTIFICATE OF DEATH.

129 D75785

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Beck

(a) Residence No. 10 N. Potomac St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Beck

6-DATE OF BIRTH (month, day and year) Oct. 9 1896

7-AGE 26 yrs. 7 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, Elizabeth Roth

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14-

(Informant) Arthur F. Beck

(Address) 10 N. Potomac St

15- MAY 15 1923 16- ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-14-23

17- I HEREBY CERTIFY, That I attended deceased from 5-10 1923 to 5-14 1923

*that I last saw her alive on 5-14 1923

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Uremia

Cardiac Hyper (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Supposed Hospital

Did an operation precede death? Yes Date of 5-11-23

Was there an autopsy? Yes

What test confirmed diagnosis? Chemical & Microscopical

(Signed) [illegible] M.D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	May 17, 1923
20-UNDERTAKER. Harry A. Arnocost	ADDRESS 4204 Ridgewood Ave

should be carefully supplied. AGE should be filled in in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

D75786 REGISTERED NO. C D75786

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Rutland Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lorenzo Jones

(Residence in Baltimore: No. 907 Rutland Ave St.; 57 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month) (Day) 1855 (Year)

7-AGE, 68 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Wilmington N C

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel J. Hensley Undertaker

(Address) 578 W. Biddle St.

15- Filed MAY 15 1923, 191.... ROBERT R. KRAUER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4 1923, to May 12 1923, that I saw h m alive on May 12 1923, and that death occurred, on the date stated above, at 11 40 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis uncertain

(Duration) yrs. mos. ds.

(Signed) R. K. Young M. D.

5/15, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Nebo DATE OF BURIAL, 5/15, 1923

20-UNDERTAKER Samuel J. Hensley ADDRESS 578 W. Biddle

N.B. Every question must be answered so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75787 74-001 D75787

CERTIFICATE OF DEATH.

D75787

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 433 E 28th St St.; 12 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Richard Henry Marshall

(Residence in Baltimore: No. 433 E 28th St St.; 20 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) 6 (Day), 1848 (Year)

7-AGE, 75 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Realestate

9-BIRTHPLACE, (State or Country) Pennsylvania

PARENTS.

10-NAME OF FATHER, Caleb Marshall

11-BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12-MAIDEN NAME OF MOTHER Jane Lewis

13-BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Marshall

(Address) 423 E 28 St.

15- MAY 15 1923, 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 13 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

May 14, 1923 (Address) 2632 Reisterstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, May 16, 1923

20-UNDERTAKER Fasciab Depper ADDRESS 1600 W North

D75788 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-00 D75788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 409 Perry st St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Hal H West

(Residence in Baltimore: No. 409 Perry St St., 64 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	Col	Divorced

6-DATE OF BIRTH. Dont Know ..... 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
52 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). " "

12-MAIDEN NAME OF MOTHER. " "

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Bank

(Address) 415 Eutaw St

15- MAY 15 1923 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

a few hours (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Tousey M. D. (Coroner.)

5-14 1923 (Address) 417 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	May 15 1923
20-UNDERTAKER,	ADDRESS
Thos Scott & Son	436 W Pratt St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 lbs.

D75789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D75789

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Riggs Ave ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Banner

(a) RESIDENCE NO. 1616 Riggs Ave ST., ... WARD .....

(Usual place of abode) dark

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Lillian Banner

6 DATE OF BIRTH (month, day, and year) Sept. 3 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day Labor

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER James Banner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co Md.

12 MAIDEN NAME OF MOTHER Hannah Wicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co Md

14 Informant Lillian Banner
(Address) 1616 Riggs Ave.

15 Filed MAY 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1923

17

I HEREBY CERTIFY, That I attended deceased from May 2 - 1923, to May 12 - 1923, that I last saw him alive on May 12 - 1923, and that death occurred, on the date stated above, at 11-0 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

dark
(duration) — yrs. 6 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Chas. L. McCardell, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 15 1923
20 UNDERTAKER James H. Lewis	ADDRESS 303 Fremont

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75790

CERTIFICATE OF DEATH.

109-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Jackson ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garnet Albert Rinick Jr.

(a) RESIDENCE NO. 1513 Jackson ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chambersburg, Pa.

PARENTS

10 NAME OF FATHER Albert Rinick Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chambersburg, Pa.

12 MAIDEN NAME OF MOTHER Naoma Schuchman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chambersburg, Pa.

14 Informant Garnet Albert Rinick Sr.
(Address) 1513 Jackson St.

15 MAY 15 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1923

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1923, to May 6, 1923,

that I last saw h alive on May 6, 1923

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows: Streptococcus Meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Tonsilitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) [illegible], M. D.

May 15 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park Cemetery. DATE OF BURIAL: May, 16, 1923.

20 UNDERTAKER: A. Howard Evans ADDRESS: #1428 S. CHarles St.

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75791 ✓ 129 D75791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 E 22d ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte E Reynolds

(a) RESIDENCE NO. 321 E 20th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bayard H Reynolds

6 DATE OF BIRTH (month, day, and year): Nov 7 1857

7 AGE: Years 66, Months 6, Days, If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Annapolis Md

PARENTS

10 NAME OF FATHER: Elijah L Rockhold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md

12 MAIDEN NAME OF MOTHER: Susan Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Annapolis Md

14 Informant (Address): Bayard H Reynolds 321 E 20th St

15 Filed 1923 19 Registrar

Date Rec'd 1111 W Preston St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 25 1921 to May 14 1923,

that I last saw him alive on May 14 1923,

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and tests

(Signed) Charles Yeo, M. D.

May 15 1923 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md — DATE OF BURIAL: May 16 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. Ditto marks should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D75792 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75792

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 South East Ave. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Briemann

(a) RESIDENCE NO. 118 S. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Briemann

6 DATE OF BIRTH (month, day, and year) 12-16-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Briemann (Address) 116 S. East Ave

15 Filed May 15 1923 Robert P. HARRISON, Registrar

Burial Permit Book.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15/23

17 I HEREBY CERTIFY, That I attended deceased from May 13 1923 to May 15 1923 that I last saw him alive on May 14/23 and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Broken Compensation (duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? By Examination

(Signed) Leo Eichelberger M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL May 18 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Nor

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D75793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-002 D75793

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2133 Wilkins Av ST., 20 WARD)

2-FULL NAME Mrs Annie Wiemeke

(a) RESIDENCE No. 2133 Wilkins ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Wiemeke

6 DATE OF BIRTH (month, day, and year): January 2nd 1859

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Berlin, Md.

PARENTS

10 NAME OF FATHER: Peter Lippert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Annie Rowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Mrs Alice Lee

(Address) 2133 Wilkins Av.

15 Robert P. Harrison, Registrar

MAY 15 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to May 15, 1923, that I last saw h alive on May 14, 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) Over yrs. mos ds.

CONTRIBUTORY (Secondary) Hardening of heart (duration) yrs. 2 mos. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Ed Lynch M. D.

5/15 1923 (Address) 1600 N. Monroe Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 18 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Monument

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S attention is called to the fact that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75794

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 18 WARD)

2-FULL NAME Miss Katherine Kelly

(a) RESIDENCE NO. 1208 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) ~~Dec~~ June 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Any.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Mamie Phillips (Address) 1208 W Franklin St

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 15 - 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1923, to May 15 - 1923.

that I last saw her alive on May 15 - 1923.

and that death occurred, on the date stated above, at 3.50 am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) myocarditis.

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edward A. Kalowski, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb 17-23

20 UNDERTAKER H. C. Draining Co

ADDRESS E. Lexington

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

15

Spec.—5-19-13—M. & T.—500 Blks.

D75795

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5114 Centre Av Germans St.: 27 WARD) REGISTERED No. C 101-00

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalina Unser

(Residence in Baltimore: No. 5114 Centre Av Germans St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Sept (Month) 15 (Day), 1849 (Year)

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Sebastian Westerman

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Kuhnaon

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Verone Unser

(Address) 5114 Centre Ave

15- Feb 9 1923, 191.. Robert F. Garrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 15 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12 1923, to May 13 1923, that I saw h[illegible] alive on May 13 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Asaute Myocarditis Dilatation of Heart

(Duration) yrs. mos. 2 ds.

(Signed) H. W. Bosley M. D.

May 14, 1923 (Address) 522 S. Sharp St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer — DATE OF BURIAL. May 16, 1923

20-UNDERTAKER H C Brauning — ADDRESS 577 N Schroeder

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

1534523

Spec. 6-9-19—H. P. Co.—1000 Blks.

(Emma J. Phillips)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75796

CERTIFICATE OF DEATH.

90 D75796

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 h Carey ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Phillips

(a) RESIDENCE. NO. 317 h Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Same~~

6 DATE OF BIRTH (month, day, and year) July 20 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Joseph A Phillips

11 BIRTHPLACE OF FATHER (city or town) Cunningham (State or country) England

12 MAIDEN NAME OF MOTHER Emma J

13 BIRTHPLACE OF MOTHER (city or town) Birmingham (State or country) England

14 Informant James B Phillips (Address) 317 Abeary

15 MAY 15 1923 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to May 15, 1923, that I last saw her alive on May 12, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Inheration of L Lung

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Grinstead, M. D.

5/15, 1923 (Address) 517 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newark N J	May 16 1923

20 UNDERTAKER H C Branning & Son ADDRESS 517 N Schroeder

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D75797

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Kachell

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1848

7-AGE.	If LESS than 1 day,
74 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 90

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Michael Kachell

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 1923 Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 13, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 29 19. 23 to May 13 19. 23

that I last saw him alive on May 13 19. 23,

and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. McKay M. D

5-14 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Patricks Cem	19....
20-UNDERTAKER.	ADDRESS
John J. Fahey & Sons	131 Light St.

MAY 15 1923

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75798

D75798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Etting ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melchor Henry Johnson

(a) RESIDENCE NO. 1209 Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Johnson

6 DATE OF BIRTH (month, day, and year) July 12-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hattie Carroll (Address) 1009 Madison Ave.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Issued.

15

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1923

17

I HEREBY CERTIFY, That I attended deceased from April 10 , 1923 , to May 12 , 1923 , that I last saw him alive on May 12 , 1923 , and that death occurred, on the date stated above, at 5-55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

chronic + (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) Chas. E. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5/16th 1923
20 UNDERTAKER	ADDRESS
Jas. H. Skinner	1620 E. Madison St

Information should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lots

D75799 3 HEALTH DEPARTMENT—CITY OF BALTIMORE

15 CERTIFICATE OF DEATH. X 175 D75799

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rilli Maritz

(a) RESIDENCE NO. 146 Main St. Newark Delaware
(Usual place of abode) ST. WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Isaac Maritz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Lukinsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Friends.

15 MAY 15 1923 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct., 17. 1922. to May 15. 1923.

that I last saw h[illegible] alive on May 15. 1923.

and that death occurred, on the date stated above, at 8. 20 A.m.

The CAUSE OF DEATH* was as follows:

Gaucher's Disease

(duration) 10+ yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 8 yrs ago.

Was there an autopsy? yes.

What test confirmed diagnosis? Post Mortem

(Signed) Horton Casparis M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del

DATE OF BURIAL May 15 19 23

20 UNDERTAKER Jack Lewis 1439

ADDRESS E Balto

INFORM should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75800

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 So. Chapel ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Bukowski,

(a) RESIDENCE NO. 608 So. Chapel ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15/23.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

PARENTS

10 NAME OF FATHER William Bukowski,

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) MD.

12 MAIDEN NAME OF MOTHER Lucy Miszkiewicz,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) MD.

14 Informant Lucy Bukowski, Mother,

(Address) 608 So. Chapel Street.

15 MAY 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to May 15, 1923, that I last saw her alive on May 15, 1923, and that death occurred, on the date stated above, at 7 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Edward Novak, M. D.

, 19 (Address) 701 N Patt PKwy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL May 16-1923

20 UNDERTAKER M. F. Sadowski. ADDRESS 705 S. Ann St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75801

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Mulberry ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Benjamin Bostw

(a) RESIDENCE NO. 909 Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	42	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A.A. Co. Md

PARENTS

10 NAME OF FATHER John H. Bostw

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co Md

12 MAIDEN NAME OF MOTHER Rachel A Coates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. Co Md

14 Informant Rachel W. Bostw (Address) 909 Mulberry St

15 Filed MAY 16 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1922 to May 13, 1923, that I last saw h alive on May 12, 1923, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Reg. W. Hoolley

(Signed) W. Hoolley, M. D.

5/16/1923 (Address) 1911 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 15 1923

20 UNDERTAKER Sam'l M. Cross & Son — ADDRESS 1400 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75802 + 31 / D75802

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 University Parkway ST., 12 WARD)

2-FULL NAME Edmund Hester Hinton

(a) RESIDENCE NO. Temporary 608 University Parkway ST. WARD .....
(Usual place of abode) Blue Ridge Summit, Pa.
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Single

5a If ~~married~~ ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Single

6 DATE OF BIRTH (month, day, and year) March 12 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	63	2	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Civil Engineer Retired
(b) General nature of industry, business, or establishment in which employed (or employer) 030
(c) Name of employer

9 BIRTHPLACE (city or town) Petersburg
(State or country) Virginia

PARENTS

10 NAME OF FATHER Erasmus O. Hinton

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Imogene Bland

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Erasmus O. Hinton Jr.
(Address) 1725 N. North Ave. Baltimore, Md.

15 MAY 16 1923 ROBERT R. KRAMER, Registrar
Burial Permit, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to May 14, 1923.
that I last saw him alive on May 14, 1923,
and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Potts Disease, Pulmonary Tuberculosis (Reported in Pneumonia by Dr Victor Cullen) Empyema Arteriosclerosis (duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Blue Ridge Summit, Pa.
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? X Ray & W. Cell Count
(Signed) W. Tunstall Taylor, M. D.
, 19 (Address) 1102 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va

DATE OF BURIAL May 17 1923

20 UNDERTAKER A. W. Jenkins & Son

ADDRESS Orchard & Mc Collough

IMPORTANT: Should be carefully supplied. Any information should be given if it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-13-22—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75803

CERTIFICATE OF DEATH.

D75803

161-04

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Lowman st. ST. 24 WARD)

2-FULL NAME Evelyn Lorenz.

(a) RESIDENCE NO. 1423 Lowman St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs---mos---ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----- ----

6 DATE OF BIRTH (month, day, and year) May 15th. 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 15 min.
	---	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Lorenz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Stanislaw Torowski.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Stanislaw Lorenz. (mother.
(Address)

15 Filed MAY 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th. 192 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth.
unknown.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto Reinhardt, M. D.
(Coroner.)

May 16th. 192 3 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Bay — DATE OF BURIAL 16 1923

20 UNDERTAKER John M. Weber 1803 ADDRESS Bank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75804 HEALTH DEPARTMENT—CITY OF BALTIMORE 170 D75804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1118 Madison Ave. St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Slenis

(Residence in Baltimore: No. 1118 Madison Ave. St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. 1873
(Month) (Day) (Year)

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper-Hanger
(b) General nature of industry, business, or establishment in which employed (or employer): 052

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Barach Slenis

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Rachael —

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Balto.

15- ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

Filed MAY 16 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Gun shot wound in head,
Instantaneous (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

May 16 1923. (Address) [illegible]

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem. Mt. Carmel	May 16 1923
20-UNDERTAKER.	ADDRESS.
Jacob Lewis,	1439 E. Balto.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75805 HEALTH DEPARTMENT—CITY OF BALTIMORE D75805

CERTIFICATE OF DEATH. 5 188-003

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 5 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Cantone

(Residence in Baltimore: No. 275 - N. Eutaw St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Feb. (Month) 16 (Day) 1919 (Year)

7-AGE: 4 yrs. 2 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): ...ld

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS:

10-NAME OF FATHER: D. Cantone

11-BIRTHPLACE OF FATHER, (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Giovanna Lauhofa

13-BIRTHPLACE OF MOTHER, (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. Cantone

(Address) 275 - Eutaw

15- MAY 16 1929 192 ROBERT R. KRAUTER, Burial Permit Clerk-trar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abdominal Injuries - post
Internal Hemorrhage Resp. Failure
by being run over by auto truck

CONTRIBUTORY (Secondary) ....mos....ds.

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D. (Coroner.)

May 16 1923 (Address) 1657 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death 1 day yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: 5/17 19 23

20-UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75806

CERTIFICATE OF DEATH.

D75806

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Kirschner

(a) RESIDENCE NO. 2913 Warrington Rd., ST., Cleveland, O. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? 30 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 0'B

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Austria

10 NAME OF FATHER Joshua Kirschner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Sarah Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant ... JOHNS HOPKINS H...
(Address)

15 MAY 16 1923 MAY 18 1923 ROBERT K. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1923, to May 15, 1923, that I last saw him alive on May 15, 1923, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Hetteman., M. D.

5-6, 1923 (Address) JOHNS HOPKINS H...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City

DATE OF BURIAL 5/16 1923

20 UNDERTAKER Wm. J. Tuckner & Son North & Pa. Ave.

ADDRESS

IMPORTANT SHOULD BE CAREFULLY supplied. AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75807

CERTIFICATE OF DEATH.

160

D75807

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McDonald:

(a) RESIDENCE NO. 6 W. Lee St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred V yrs. V mos. V ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	V	V	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)

PARENTS

10 NAME OF FATHER Edward McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Silber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Julia Silber. (Address) 2-99 Cumberland

15 FILED MAY 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to May 16, 1923, that I last saw him alive on May 16, 1923, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Hemolytic Jaundice

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Cameron, M. D.

5/16 1923 (Address) South Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	May 16 1923
20 UNDERTAKER J. Feinman & Bro	ADDRESS 1127 E Balto

CAUTION should be taken to correctly supplied. ALL items should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75808

D75808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1841 Collington ave St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Hill

(a) Residence No. 1841 Collington ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6-DATE OF BIRTH (month, day and year): Aug 1 1862

7-AGE: 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: R.R. Baggage Master

(b) General nature of industry, business, or establishment in which employed (or employer): B&O

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Andrew Hill

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Pinkerton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-Informant: Henrietta Hill

(Address): 1841 Collington Ave

15-MAY 16 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 15, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 10 1923 to May 15 1923

that I last saw him alive on May 15 1923,

and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John R Caguy, M. D

, 19 (Address) 1603 N Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lacatan Accomac Co Va

DATE OF BURIAL: May 17 19 23

20-UNDERTAKER: George J Smith

ADDRESS 1532 Hollins

Spec—12-23-21—R.B.R.S.—400 Pds.

D75809

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-08 D75809

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Saunders

(a) Residence No. 1840 E. Spring St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Married ?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Husband ?

6-DATE OF BIRTH (month, day and year) 1869 ?

7-AGE.	If LESS than 1 day.
54 ? yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md Powhatan Co?

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md Powhatan Co

12-MAIDEN NAME OF MOTHER, Elizbeth Fitchett?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country) Md Powhatan Co

14- (Informant) Municipal Hospital Records

(Address) Wife Mrs Frank Saunders 1840 E Spring St

15- Filed MAY 16 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 13, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 7, 19 23 to May 13 19 23

that I last saw h. alive on May 13 19 23

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. G. Wickes, M. D.

5-14 19 20 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Leon Cemetery Govanstown	May 17 1923
20-UNDERTAKER.	ADDRESS
Jno R A Elliott	1725 Ashland Av

Should be carefully filled in all items, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75810

D75810

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Lafayette ave ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence A. Thompson

(a) RESIDENCE NO. 505 Lafayette ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 54 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Porter

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Allen Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Catherine Bates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs C A Thompson

(Address) 505 Lafayette Ave

15 FILED MAY 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1922, to 5/15, 1923.

that I last saw h~ alive on 5/13, 1923,

and that death occurred, on the date stated above, at 9:25 p m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Acute Insufficiency

(duration) ... yrs. 7 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Benj R Krauter, M. D.

5/15, 1923 (Address) 2139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 16 1923
20 UNDERTAKER	ADDRESS
Mrs Robert F Elliott	Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75811 D75811

CERTIFICATE OF DEATH. 76 129

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 824 So. Clinton St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Katherine Datzer

(Residence in Baltimore: No. 824 So. Clinton St.; yrs. 40 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Apr 7th 1837
(Month) (Day) (Year)

7-AGE. 86 yrs. 1 mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rosa Roth

(Address) 824 So. Clinton St

15-MAY 16 1923 Filed ..... 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 13th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Bu Dorton M. D.
(Coroner)

May 16 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or, if Death Was From Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Sacred Heart Cem.	May 16. 1923.
20-UNDERTAKER, Lilly & Zeiler	ADDRESS 403 N Wolfe St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75812

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D75812

CERTIFICATE OF DEATH.

26

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert H. Kraemer

(Residence in Baltimore: No. 1223 S. Clinton St St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Single

6-DATE OF BIRTH, April 6/1922, 1..... (Month) (Day) (Year)

7-AGE. 1 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Chas. W. Kraemer

11-BIRTHPLACE OF FATHER, (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Laura Masson

13-BIRTHPLACE OF MOTHER, (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. W. Kraemer

(Address) 1223 S. Clinton St.

15- Filed MAY 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia- Empyema both sides

(Autopsy at hospital)

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) J. S. Culler M. D.
(Coroner)

5/15/ 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cem.	May 17, 1923

20-UNDERTAKER,	ADDRESS
Lilly & Zeiler.	403 S. Wolfe St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75813

CERTIFICATE OF DEATH.

+ 90 D75813

REGISTERED NO.

1-PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4 ST., WARD)

2-FULL NAME John H. Webb

(a) RESIDENCE NO. Ellicott City, Md. ST., WARD Ellicott City Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

5/51

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olivia Webb

6 DATE OF BIRTH (month, day, and year) Oct 21 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
70	72	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Univ. Hospital records

(Address)

15 FILED MAY 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/1, 1923, to 5/14, 1923, that I last saw h.. alive on 5/14, 1923, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. benign prostatic hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/13/23

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) W Faelicten, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cem DATE OF BURIAL May 16 1923

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

N. B.—All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75814

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead at St Agnes Hospital 25 188-003 Registered No. C.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Mary C. Harman

(Residence in Baltimore: No. Ellicott City Md ..... St.; yrs. ..... mos. 1 ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	Married

6-DATE OF BIRTH. Oct. (Month) 31 (Day) 1855 (Year)

7-AGE. 67 yrs. 6 mos. 15 ds. If LESS than 1 day ..... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Duties

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. James Be Craft

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Margaret Mathews

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Phillip J. Harman

(Address)..... Ellicott City Md.

MAY 16 1923 Filed 192

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 15 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or Inquiry) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull
Rt Thumb Leg & arm
Automobile Accident Man down on the Road Unknown

(Duration) ..... yrs.

CONTRIBUTORY (Secondary) Internal Hemorrhage

(Duration) ..... yrs. ..... mos. 1 hr ..... ds.

(Signed) Jones M. Fenton M. D. (Coroner.)

May 15 1923 (Address) 700 E Lane St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? Frederick Rd Howard Co

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Johns Cem	May 17 1923
20-UNDERTAKER.	ADDRESS.
Edston Sons	Ellicott City

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form—12-23-21—E.D.P.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75815

CERTIFICATE OF DEATH.

14 129 D75815

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1435 Mt Royal Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Elizabeth Starr

(a) Residence No. 1435 Mt Royal Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Starr

6-DATE OF BIRTH (month, day and year) Jany 5/1849

7-AGE. 74 yrs. 4 mos. 10 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Thomas J Sunwalt

11-BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country),

12-MAIDEN NAME OF MOTHER, Matilda J Peters

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country),

14-(Informant) Mary Starr Robins

(Address) 1435 Mt Royal Ave

15- MAY 16 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 4 1923 to May 15 1923

that I last saw h.. alive on May 15 1923,

and that death occurred, on the date stated above, at 12.45 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical test

(Signed) Mitchell Thomas M. D.

, 19 (Address) 330 E Chase St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Greenmount Cemetery	May 18 1923
20-UNDERTAKER,	ADDRESS
Harry H Armacost	4204 Reisterstown Rd

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D75816

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2229 Ethel St. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Edna Costley

(Residence in Baltimore: No. 2229 Ethel St

St.: yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	colored	single

6-DATE OF BIRTH, May 14, 1923
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... (infant)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, April Greenaway

11-BIRTHPLACE OF FATHER (State or Country), West Indies

12-MAIDEN NAME OF MOTHER Pearl V. Costley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pearl V. Costley

(Address) 2229 Ethel St

15- MAY 16 1923 ROBERT R. KRAUTER,
Filed....., 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
.....find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:

.....Acute Pneumonia

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	May 16 1923
20-UNDERTAKER	ADDRESS
Joseph A Farrell	2314 Pinkney St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75817

CERTIFICATE OF DEATH.

X 90 D75817

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Providence Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Herbert Howard

(a) RESIDENCE NO. Brookville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marion Howard

6 DATE OF BIRTH (month, day, and year): June 1872

7 AGE: Years 30 4 25 | Months \ | Days \ | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Greenbury Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Nettles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John Murphy

(Address): 1 N Durham St

15 MAY 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from March 18th, 1923, to May 15th, 1923, that I last saw h[illegible] alive on May 14th, 1923, and that death occurred, on the date stated above, at 11.30A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(duration) \ yrs. 3 mos \ ds.

CONTRIBUTORY (Secondary): Rheumatic fever not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brookville Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Harry F. Brown, M. D.

5/5, 1923 (Address) 50 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Christy, Md. (Unity) DATE OF BURIAL: May 18, 23

20 UNDERTAKER: John M. Johnson ADDRESS: 1809 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75818

CERTIFICATE OF DEATH.

D75818

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 Harford Ave. WARD) 10

2-FULL NAME M. Isabelle Yakel

(a) RESIDENCE NO. 1134 Harford Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If ~~married, widowed,~~ or divorced HUSBAND of (or) WIFE of Andrew M. Yakel

6 DATE OF BIRTH (month, day, and year) March 23 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Edward Browning.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louise Swain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant M. Andrew M. Yakel

(Address) 1134 Harford Ave

15 MAY 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to May 15, 1923, that I last saw h alive on 19 and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John [illegible] M. D.

5/16/1923 (Address) 936 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 18 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75819

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75819

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 McElderry St., 5 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula Thomas

(Residence in Baltimore: No. 1111 McElderry St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	black	married

6-DATE OF BIRTH. unknown (Month) 1..... (Day) (Year)

7-AGE.	If LESS than 1 day,
52 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Georgia

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Ames

(Address) 1111 Mc Elderry

15- Filed MAY 16 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably cardiac valvular insuffiency. (Diagnosed by Dr. Carsill 8 mons. ago.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C. J. Pullen M. D. (Coroner.)

5/15/23 192.... (Address) 5pi E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Ashbury Cemetary — DATE OF BURIAL, May 17, 1923

20-UNDERTAKER. Joseph T. H Rochester — ADDRESS 413 Jefferson St

I. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH

D75820

✓ D75820

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Hillen ST.: 5 WARD)

2-FULL NAME Turner Williams

(a) RESIDENCE. No. 1008 Hillen ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Married

5a If married, ~~widowed, or divorced~~
HUSBAND ~~or~~ (or) ~~WIFE~~ of Alveta Williams

6 DATE OF BIRTH (month, day, and year) 42 yrs.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Alveta Williams
(Address) 1008 Hillen St

16 1923 Robert J. Harrison, Registrar
19 0383

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10 1923

17

I HEREBY CERTIFY, That I attended deceased from 5/13, 19 23, to 5/15, 19 23, that I last saw h[illegible] alive on May 15, 19 23, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) A. H. Hamilton, M. D.

5/16, 19 23 (Address) 1322 Hopkins Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: MAY 16 1923

20 UNDERTAKER

ADDRESS

Bureau of Vital Statistics

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21—E.B.R.B.—400 Blks.

D75821

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D75821

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2436 N. Calvert Street St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James White Clayton

(a) Residence No. 2436 N Calvert Street St., 12 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? 49 yrs. 4 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write which) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) Dec. 21-1873

7-AGE. 49 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Sec'y. to Mayor

(b) General nature of industry, business, or establishment in which employed (or employer)..... of Balto. City

(c) Name of employer..... City of Balto.

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS:

10-NAME OF FATHER. John Polk Clayton

11-BIRTHPLACE OF FATHER (city or town)..... Cecil
(State or Country)..... Maryland

12-MAIDEN NAME OF MOTHER. Mary A Johnson

13-BIRTHPLACE OF MOTHER (city or town)..... Elkton
(State or Country)..... Maryland

14- (Informant) Miss. Ellen C Clayton (sister)
(Address) 2436 N. Calvert Street.

15- Filed..... Robert F. Garrison, Registrar.

16 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14 1923

17- I HEREBY CERTIFY, That I attended deceased from May 9 - 1923 to May 14 1923

that I last saw him alive on May 14 1923

and that death occurred, on the date stated above, at 4.30P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Wm T Walsh M. D

May 15, 1923 (Address) 2128 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cemetery — DATE OF BURIAL. May-17-23

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOO[illegible], Successor) — ADDRESS 208 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D75822

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3825 Boarman Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francesco Parmigiani

(a) RESIDENCE No. 3825 Boarman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Benasi

6 DATE OF BIRTH (month, day, and year) Dec 14-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Ugo M. Parmigiani

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Giulia Mugarelli

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Luco M. Parmigiani

(Address) 3825 Boarman Ave

15 Robert P. Harrison, Registrar

16 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923 to May 15, 1923, that I last saw him alive on May 14, 1923 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi S. Di Stefano M. D.

May 16, 1923 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 18 1923
20 UNDERTAKER	ADDRESS
George F. Ruth	1733 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D75823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75823

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 S. Regester ST.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Gaskins

(a) RESIDENCE. No. 30 S. Regester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) C70

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Hettie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Eliza Drake (Daughter)
(Address) 30 S. Regester st

16 1923 Robert P. Madison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 12th, 1923, to May 14th, 1923, that I last saw her alive on ..., 1923 and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L Wisner, M. D.

5/15, 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	5/17 1923
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Broad st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICAL CERTIFICATE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 S. Ellwood Ave. St., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Kenny

(a) RESIDENCE NO. 828 S Ellwood ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Patrick Kenny

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Anna Kenny (Address) 828 S. Ellwood ave.

15 Filed May 16 1923 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17

I HEREBY CERTIFY, That I attended deceased from May 11, 1923, to May 14, 1923,

that I last saw her alive on May 14, 1923,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. L Burke, M. D.

May 16 1923 (Address) 8042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. Cemetery	May 17 1923
20 UNDERTAKER	ADDRESS
John A. Moran Sons	E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

16 1923

Spec. 6-9-19—H. P. Co.—1000 Blks.

D75825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75825

CERTIFICATE OF DEATH.

11-00

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Eastern ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelo Seolo

(a) RESIDENCE. No. 819 Eastern ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Rocco Seolo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Mary Salessandro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Rocco Seolo
(Address) 819 Eastern ave

15 Filed . 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MAY 16 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12 , 1923 , to May 15 , 1923

that I last saw him alive on May 15 , 1923

and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) La Grippe
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valvachino M. D.

May 16, 1923 (Address) 141 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 17 1923
20 UNDERTAKER	ADDRESS
Wendell Appel & Son	373 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- H.B.R.S.—400 Bks.

D75826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Skinner

(a) Residence No. 427 E. 23rd St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1842

7-AGE. 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Calvert Co., Md.

PARENTS.

10-NAME OF FATHER. John Rhoden

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Charlotte Snow

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md ?

11- (Informant) Municipal Hospital Records

(Address)

15- MAY 16 1923 Robert J. Harrison, 192 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 11, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 21 19 23 to May 14 19 23

that I last saw h. alive on May 14 19 23

and that death occurred, on the date stated above, at 6:55 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. M. Powell M. D

5-15-. 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Huntingtown Md DATE OF BURIAL May 16 19 23

20-UNDERTAKER Samuel Hemsley ADDRESS 578 N. Eden

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

162 46 D75827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 90 D75827

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. .....

CITY OF BALTIMORE: (No. " " " ST., 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Winter.

(a) RESIDENCE NO. 615 George St. Youngstown, Ohio WARD Youngstown Ohio
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored.	Married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Sallie Winter (wife).

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Sam Winter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Charlotte Stewart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL

15 MAY 16 1923 Robert ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to May 14, 1923, that I last saw him alive on May 14, 1923, and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted, if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Blood culture

(Signed) E. Cowles Andrus M. D.

JOHNS HOPKINS HOSPITAL 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Clinton Cem. DATE OF BURIAL May 17 23

20 UNDERTAKER Samuel H. Hemsley ADDRESS 1128

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec-12-23-21-B.B.R.S.-400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75828

CERTIFICATE OF DEATH.

162

D75828

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2024 Gough St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia A. Malenda

(a) Residence No. 2024 Gough St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, X Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 15 1923

7-AGE. ...yrs. ...mos. 1 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Frank Malenda

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Agatha Tobarska

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Baltimore

14- (Informant) Frank Malenda

(Address) 2024 Gough

15- Filed MAY 17 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16 1923

17- I HEREBY CERTIFY, That I attended deceased from: May 15 1923 to May 16 1923

that I last saw h. alive on May 16 1923

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Colitis

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ...Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) William J. Ryan M. D.

May 17 1923 (Address) 801 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	May 17 1923
20-UNDERTAKER.	**ADDRESS**
John H. Weber	1803 Bank

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75829

CERTIFICATE OF DEATH.

90 D75829

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S. Fremont ave ST. 12 WARD)

2-FULL NAME Sarah Goldstein

(a) RESIDENCE NO. 305 S. Fremont ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Ellia Abrams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Sarah Goldstein

(Address) 305 S Fremont ave

15 Filed MAY 17 1923 [illegible] KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1921, to May 16, 1923, that I last saw h[illegible] alive on May 8, 1923, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein M. D.

5/16, 1923 (Address) 733 Augusta st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Bl — DATE OF BURIAL: 5/19 1923

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS 1127 E. Balto st

REASON SHOULD BE GIVEN why any question is not answered. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75830 615 D75830

HEALTH DEPARTMENT—CITY OF BALTIMORE

JOHNS HOPKINS HOSPITAL

CERTIFICATE OF DEATH. 100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 02 WARD)

2-FULL NAME Lula Young

(a) RESIDENCE NO. 620 Wagner ST., City WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Young

6 DATE OF BIRTH (month, day, and year) March 27, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Anne Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant ..... JOHNS HOPKINS HOSPITAL

(Address) .....

15 MAY 17 1923 RUSSELL R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1923, to May 15, 1923,

that I last saw her alive on May 15, 1923

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Generalized lupus erythematosus

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) terminal mos. ..... ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) E. Cowles Andrus, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL May 18 1923

20 UNDERTAKER John H. Soadview — ADDRESS 1027 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75831

CERTIFICATE OF DEATH.

90 D75831

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 551 Walnut ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Hudson

(a) RESIDENCE. No. 551 Walnut ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hudson

6 DATE OF BIRTH (month, day, and year) June 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Emma Hudson

(Address) 551 Walnut St.

15 MAY 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to May 14, 1923, that I last saw him alive on May 14, 1923, and that death occurred, on the date stated above, at 6.45-10, m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carl L Green M. D.

5-10, 1923 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 17 1923

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75832

CERTIFICATE OF DEATH. 74-001 D75832

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 E. Monument ST. 10 WARD)

2-FULL NAME Estelle V. Savage

(a) RESIDENCE NO. 1014 E. Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Savage

6 DATE OF BIRTH (month, day, and year) Sept. 1 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
~~1868~~	54	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas. Askins

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Stevenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr John M. Savage

(Address) 1014 E. Monument.

15 Filed MAY 17 1923 ALBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1923, to May 14, 1923, that I last saw her alive on May 14, 1923, and that death occurred, on the date stated above, at 6A.M.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ....., ...

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A. Hastings, M. D.

M. D. 1923 (Address) 712 S. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL May 17 1923

20 UNDERTAKER Mrs J. G. Locks ADDRESS 1302 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75833

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75833

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Ridgely ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Naylor

(a) RESIDENCE NO. 1013 Ridgely ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Margaret Naylor

6 DATE OF BIRTH (month, day, and year) Feb 8 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Benny Naylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Miss Mary Naylor (Address) 1013 Ridgely St

15 MAY 17 1923 ROBERT P. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1923, to May 16, 1923, that I last saw him alive on May 16, 1923, and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Uterus Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford A. Draper, M. D.

, 19 (Address) 1217 Mosher Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	5-18 1923
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75834

CERTIFICATE OF DEATH.

61-001 D75834

1-PLACE OF DEATH West End Mty 18 REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 112 N. Calhoun St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Martin

(Residence in Baltimore: No. 837 w Fayette Street St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	

6-DATE OF BIRTH, May 14, 1923 (Month) (Day) (Year)

7-AGE, ...yrs. .....mos. .....da. If LESS than 1 day, 13 hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Mr Paul Martin

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Frances Kenton

13-BIRTHPLACE OF MOTHER (State or Country). Harrington Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Schwenkel

(Address) West End Mty

15-

Filed MAY 17 1923 19 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10 1923, to May 15 1923, that I saw h.. alive on May 10 1923, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Im perfect respiration

(Duration) .....yrs. .....mos. 1/2 da.

CONTRIBUTORY (Secondary) Prematurity

(Duration) .....yrs. .....mos. .....ds.

(Signed) Bernard Connell Mull M. D.

May 15, 1923 (Address) 1038 Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Peters Cemetery	May 16, 1923.
20-UNDERTAKER,	ADDRESS
Robert J. Cowan	901 Hollins St.

important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D75835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75835

CERTIFICATE OF DEATH.

41-102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Pressman St. 14 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew E. Overton

(a) RESIDENCE. No. 410 Pressman St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mattie Overton

6 DATE OF BIRTH (month, day, and year) Feb 19, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Elizabeth City, N.C.

PARENTS

10 NAME OF FATHER Joseph J. Overton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elizabeth City, North Carolina

12 MAIDEN NAME OF MOTHER Christie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Mattie Overton (Address) 410 Pressman

15 MAY 17 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to May 14, 1923, that I last saw h[illegible] alive on May 13, 1923, and that death occurred, on the date stated above, at 12.02 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Sequel of Influenza.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

May 14, 1923 (Address) 1209 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 17th 1923
20 UNDERTAKER	ADDRESS
Albert A. Elliott	1425 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAT—1500 Blks.

D75836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D75836

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 508 S Paca ST., 1 WARD)

2-FULL NAME Joseph Nkonchek

(a) RESIDENCE No. 508 S Paca ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Inf.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7/23

7 AGE — Years — Months — Days: 10 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER Michael Nkonchek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Stella Nkonchek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address):

Filed MAY 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Mark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to May 15, 1923,

that I last saw h[illegible] alive on May 15, 1923

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Enumeration

(Premature birth)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical signs

(Signed) Harold Fisher, M. D.

19 (Address) 232 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus — DATE OF BURIAL: May 19 19[illegible]

20 UNDERTAKER: Jos. Gobleiewski — ADDRESS: 1145 S. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Dallas ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Thomas

(a) RESIDENCE NO. 1117 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Eliza Thomas

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Quarry

(c) Name of employer Balto.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Eliza Thomas

(Address) 1117 N. Dallas St.

15 MAY 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/9/, 1923, to 5/15/, 1923, that I last saw h alive on May 15, 1923, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Fibrosus Pleurisy

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. Robinson, M. D.

5/16/23 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National — DATE OF BURIAL May 18 1923

20 UNDERTAKER John W Henderson — ADDRESS 1503 E monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tuberculosis

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75838

CERTIFICATE OF DEATH.

31 ✓ D75838

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1463 Annapolis Ave ST.; Mt Lowan WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Stubbins

(Residence in Baltimore: No. 1463 Annapolis Ave Sex Fife yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Oct 27, 18[illegible]
(Month) (Day) (Year)

7-AGE, 79 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Richard Woods

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Seaman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph R Stubbins

(Address) 625 S Fremont Ave

15- MAY 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1923, to May 16 1923, that I saw her alive on May 12 1923, and that death occurred, on the date stated above, at 4.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Phthisis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Raymond O Williams M. D.

May 16, 1923 (Address) Lakeland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Mem. DATE OF BURIAL, May 18, 1923

20-UNDERTAKER Wm Cook ADDRESS 922 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D75839 HEALTH DEPARTMENT—CITY OF BALTIMORE D75839

CERTIFICATE OF DEATH.

22 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST. Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Coleman. (C)

(a) RESIDENCE No. 156 W. Hamburg St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Standard Fertiliz-
(c) Name of employer ing Company.

9 BIRTHPLACE (city or town) (State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Allen B. Frazier. (C) (Address) 717 S. Fremont Ave.

15 Filed MAY 17 1923 ROBERT H. KRAUTH, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th. 1923 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

May 17, 1923 (Address) 1017 E. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Standard Fertilizing Co.

Former or usual residence Curtis Bay.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cemetery DATE OF BURIAL May 17 1923

20 UNDERTAKER Michael Doyle. ADDRESS 15 E. Lee St.

CAUSE OF DEATH should be plainly written, so that it may be properly classified. See instructions on back of certificate.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75840

CERTIFICATE OF DEATH.

100-001 D75840

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 15 WARD) E

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Hall

(a) RESIDENCE NO. 1818 Forman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced, (write the word)
M.	colored	baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) May 9-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	/	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Hall

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) md.

12 MAIDEN NAME OF MOTHER Annie Tra...

13 BIRTHPLACE OF MOTHER (city or town) Va...
(State or country)

14 Informant Ann Hall
(Address) 1818 Forman St

15 Filed MAY 17 1923 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 15th, 1923, to May 16, 1923, that I last saw h[illegible] alive on May 16, 1923, and that death occurred, on the date stated above, at 4:10 a m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) yrs. 0 mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Helen Fretwell, M. D.

1923 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dick Hopkins	May 16 1923
20 UNDERTAKER	ADDRESS 1303
Wm A. Lemmon	Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75841 D75841

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1023 Booth ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A Bryan

(Residence in Baltimore: No. 1023 Booth St.; 23 yrs. 5 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec (Month) 3 (Day), 1899 (Year)

7-AGE, 23 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm H. Bryan

11-BIRTHPLACE OF FATHER (State or Country), A. A. Co Md

12-MAIDEN NAME OF MOTHER Celia Hall

13-BIRTHPLACE OF MOTHER (State or Country), A. A. Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Celia Bryan

(Address)..... 1023 Booth

15-

Filed....., 191.....

MAY 17 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 14 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 3rd 1923, to May 14 1923, that I saw h[illegible] alive on May 23rd 1923, and that death occurred, on the date stated above, at 2.05 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration)..... yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) F. C. Funk M. D.

May 14 1923 (Address) 131 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Balto Md.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, May 17 1923

20-UNDERTAKER James H. Lewis | ADDRESS 503 Eastern Ave.

D75842 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

113 D75842

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1139 Parish St. ST.: 16 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Jacobs

(Residence in Baltimore: No. 1139 Parish St. St.: yrs., 1 mos. 12 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	colored	single

6-DATE OF BIRTH, April 3, 1923
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 12 da. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Thos. Greenway

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Jacobs

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jacobs

(Address) 1139 Parish St

15-[illegible]

Filed MAY 17 1923, 191.. ROBERT B. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary) no history

(Duration) ...yrs. ...mos. ...da.

(Signed) T. Kennedy M. D.
(Coroner.)

May 16, 1923 (Address) 1139 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...da. In the State ...yrs. ...mos. ...da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn DATE OF BURIAL, May 17 1923

20-UNDERTAKER James H. Dennis ADDRESS 1303 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Linwood R. Williams

D75843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75843

CERTIFICATE OF DEATH.

X 188-601

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Penna. R.R. Yards St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Linwood R. Williams

(Residence in Baltimore: No. Bowie, Md., St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. about 1879

(Month) (Day) (Year)

7-AGE 43 11

yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work R. R. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Wm A C Williams

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Robertson

13-BIRTHPLACE OF MOTHER, (State or Country). Illinois

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Jesse M Williams (Informant)

A. J. Marshall

Landover Md 3539 Falls Rd (Address)

15- MAY 17 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16, 1923.

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

R. R. accident (struck by engine)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessey, M. D. (Coroner.)

May 17 1923. (Address) 530 Fidelity Bldg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Bowie Md

19-PLACE OF BURIAL OR REMOVAL. Bowie Md DATE OF BURIAL. May 17 1923

20-UNDERTAKER. A. J. Marshall ADDRESS 3539 Falls Rd

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-23-21—E.B.P.S.—400 Blks.

D75844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75844

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2221 Gough St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cieslak

(a) Residence No. 2221 Gough St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): X

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 6 1920

7-AGE. 2 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: William Cieslak

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Frances Danelak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14-

(Informant) William Cieslak

(Address) 2221 Gough St

15-FILED MAY 17 1923. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16/23

17-I HEREBY CERTIFY, That I attended deceased from May 7 1923 to May 16 1923

that I last saw him alive on May 16 1923

and that death occurred, on the date stated above, at 9.50 P.M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Uraemic Convulsions

(Duration) yrs. mos. 3 hrs ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) Leo Heller, M. D.

5-17-, 1923 (Address) 1937 Smith

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: May 17 1923

20-UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75845

CERTIFICATE OF DEATH.

11-001 ✓

REGISTERED NO. D75845

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 N Rand ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George D. Mathews

(a) RESIDENCE. No. 82 Ashland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)
Male	Col	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Mathews

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Rose Winson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Rose Mathews
(Address) 82 Ashland Ave

15 Filed MAY 17 1923 ROBERT M. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1923, to May 16, 1923, that I last saw h.. alive on May 15, 1923, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Probable Influenza

(duration) yrs. mos 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Clyde Burns, M. D.

, 19 (Address) 218 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashbury Cemetary	May 18 1923
20 UNDERTAKER	ADDRESS
Joseph T. H. Rochester	1413 Eutaw st

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75846

CERTIFICATE OF DEATH.

101-00 D75846

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 China ST., 22 WARD)

2-FULL NAME Horace Coles

(a) RESIDENCE NO. 804 China ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) April 2 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ford carrier

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Schollett Wirt W. Va.

PARENTS

10 NAME OF FATHER Edward Coles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Schollett Wirt W. Va.

12 MAIDEN NAME OF MOTHER Antonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wife Lizzy Coles 804 China St

15 MAY 17 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/1923

17

I HEREBY CERTIFY, That I attended deceased from 5/10/1923 to 5/14/1923

that I last saw him alive on 5/14/1923

and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Bronchites

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Cameron Bosley M. D.

5/15/1923 (Address) 908 E Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL May 17 1923

20 UNDERTAKER Jas Geo H. Kooper

ADDRESS 404 N Conway St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75847

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75847

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1456 Riverside ave ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh P. Bergen.

(a) RESIDENCE. No. 1456 Riverside Ave ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie Kennedy

6 DATE OF BIRTH (month, day, and year) [illegible] 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ex dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 125

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Hugh P. Bergen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Bergen

(Address) 1456 Riverside ave

15 Filed MAY 17 1923 ROBERT R. KRAUTER,

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 16. 23.

17

I HEREBY CERTIFY, That I attended deceased from 10. 1. 22. 19 , to 5. 16. 23. 19 ,

that I last saw him alive on 5. 16. 23 19 ,

and that death occurred, on the date stated above, at 7.45A m.

The CAUSE OF DEATH* was as follows:

myocarditis

Generalized arteriosclerosis

Auricular Fibrillation

(duration) not determined yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilitation

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) J. Edward Norris M. D.

5/16. 1923 (Address) 1430 Riverside ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	5/18 1923
20 UNDERTAKER	ADDRESS
J. Bailey Dorsey	318 Light St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75848

CERTIFICATE OF DEATH.

129

D75848

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 19 Rectory Road ST., 27 WARD)

2-FULL NAME John Evans Buckley

(a) RESIDENCE NO. 19 Rectory Road ST. 27 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Wm A R Buckley

6 DATE OF BIRTH (month, day, and year): 1866 July 19

7 AGE: Years 57 Months 3 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manf Acid Phosphate Fertilizer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Port Deposit Md

PARENTS

10 NAME OF FATHER: Jesse Buckley M D

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cecil

12 MAIDEN NAME OF MOTHER: Georgia Brangton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Port Deposit Md

14 Informant (Address): Wm A R Buckley wife 19 Rectory Rd

15 MAY 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from March 7, 19 23, to May 16, 19 23, that I last saw him alive on May 15, 19 23, and that death occurred, on the date stated above, at 1.40 a m.

The CAUSE OF DEATH* was as follows:

Uremia Sclerosis
Hypertrophied Heart
Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no knowledge

Did an operation precede death? no Date of .....

Was there an autopsy? no, moribund

What test confirmed diagnosis? Symptoms and

(Signed) William J Todd, M. D.

19 (Address) 1101 Washington

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudwell Cem Co. Md	May 18 1923

20 UNDERTAKER: John O Mitchell ADDRESS: 1201 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 lbs.

Smith 700 Pat-Park Ave

D75849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75849

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2248 McElderry St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Otto

(a) Residence No. 2248 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Otto

6-DATE OF BIRTH (month, day and year) Nov 6 1844

7-AGE, 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Albert Otto

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Dorothea Kunz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Mrs Bertha Otto

(Address) 2248 McElderry

15- Filed 7 1923, 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16 1923

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to May 16, 1923, that I last saw h[illegible] alive on May 15, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

Arteriosclerosis (Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John B Lucas M. D.

5/16, 1923 (Address) 718 N Pat Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore DATE OF BURIAL, May 19, 1923

20-UNDERTAKER, Wm Cook ADDRESS 502 E North Ave

Please print plainly, so that it may be properly examined. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75850

D75850

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1900 Mosher St. 16 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt E Eccleston

(a) RESIDENCE. No. 1900 Mosher St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of husband of Mary E Eccleston

6 DATE OF BIRTH (month, day, and year) Jan 10, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work horseshoer retired

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hereford Balto Co. Md.

PARENTS

10 NAME OF FATHER James Eccleston.

11 BIRTHPLACE OF FATHER (city or town) Nottingham (State or country) England

12 MAIDEN NAME OF MOTHER Julia A Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Anna L. Walters (Address) 70 Calvert Ave

15 MAY 17 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14 1923 to May 15 1923, that I last saw h alive on May 15 1923, and that death occurred, on the date stated above, at 7.50 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy Mellon M. D.

(Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U. B. National Cemetery	May 18 1923
20 UNDERTAKER William Cook	ADDRESS 502 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75851

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-D75851
002

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 Fremisburg Place 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Andrew Shaeffer

(a) Residence No..... 1709 Fremisburg Place ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, ~~Married~~ Widowed, ~~Widowed~~ or Divorced. (Write the word.) Widower

5a-If married, widowed, or ~~divorced~~ HUSBAND of ~~(or WIFE)~~ of Mary C. Shaeffer

6-DATE OF BIRTH (month, day and year) July 24-1855

7-AGE, ~~15~~ 67 yrs. 9 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired formerly

(b) General nature of industry, business, or establishment in which employed (or employer)..... Dairy Co.

(c) Name of employer..... Mills Bowring

9-BIRTHPLACE (city or town) (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, Andrew Shaeffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Howard Co. Md

12-MAIDEN NAME OF MOTHER, Sarah Selby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Howard Co Md

14- (Informant)..... Edward Shaeffer

(Address)..... 1709 Fremisburg Place

15- Filed ..... 19.. Robert F. Garrison, Registrar.

D 86

77923

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 17, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 22 to May 17 23

that I last saw him alive on May 16 23

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis & Infirmities of old age

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? ~~yes~~ 1709 Fremisburg

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Chas. H. Bubert, M. D.

May 17 1923 (Address) 1100 W Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn — DATE OF BURIAL, May 19 23

20-UNDERTAKER. Wm. Tevis Sons & E. Hartsock — ADDRESS

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec– 12-23-21– E.B.P.S.—400 Blks.

D75852

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Charles Koestler.....

(a) Residence No. 943 Linden Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widowed

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of widowed

6-DATE OF BIRTH (month, day and year) Aug. 24 1847

7-AGE. 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS

10-NAME OF FATHER. Unknown?

11-BIRTHPLACE OF FATHER (city or town). ? (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown?

13-BIRTHPLACE OF MOTHER (city or town). ? (State or Country). Unknown

14- (Informant) Municipal Hospital Record

(Address) Eddy Koestler 152 Eutaw Place

15-

Filed 1923 Robert P. Harrison, Registrar.

17 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 15, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 25 19 23 to May 15 19 23

that I last saw him alive on May 15 19 23

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Powell M. D

5-16-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Marys Hampden — DATE OF BURIAL, may 16, 1923

20-UNDERTAKER, Wm Cook — ADDRESS 502 E Monument

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 Light ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Hammond

(a) RESIDENCE NO. 1636 Light ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Hammond

6 DATE OF BIRTH (month, day, and year) Dec 4 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. R. 078

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Philip C. Hammond

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hammond

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mrs E. Hammond (Address) 1636 Light

15 Robert F. Garrison, 19 Registrar

171923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1923, to May 17, 1923, that I last saw h[illegible] alive on May 17, 1923 and that death occurred, on the date stated above, at 1-30 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. P. Campbell M. D.

May 17, 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 21 1923
20 UNDERTAKER	ADDRESS
John Fields	1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Blks.

D75854
162 Wash

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75854

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Richard Gross

(a) RESIDENCE NO. 1358 Stockton St ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Mar. 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster packer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 JOHNS HOPKINS HOSPITAL Informant (Address)

15 Filed ..... , 19 ..... Robert P. Harrison, Burial Permit Clerk. Registrar

17139

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 11, 1923, to May 15, 1923, that I last saw him alive on May 15, 1923, and that death occurred, on the date stated above, at 4:57 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic aortitis —

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? Residence —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Coates Andrus —, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md

DATE OF BURIAL 5-17 1923

20 UNDERTAKER Daniel Easton

ADDRESS Pa ne

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75855

100-00

D75855

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 N. Gilmor ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Forest.

(Residence in Baltimore: No. 1012 N. Gilmor St.; ....yrs., 3 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH. May (Month) 14 (Day), 1923 (Year)

7-AGE. ....yrs. 3 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. James Forest

11-BIRTHPLACE OF FATHER (State or Country). Washington DC

12-MAIDEN NAME OF MOTHER. Paulinne Smith

13-BIRTHPLACE OF MOTHER (State or Country). New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Paulinne Forest

(Address) 1012 N. Gilmor St.

15-

Robert L. Garrison,

Filed....., 191.....

Registrar.

Burial Permit Clerk.

171923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 17th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16 1923, to May 16 1923, that I saw him alive on May 16th 1923, and that death occurred, on the date stated above, at 12.00 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonic Tuberculosis

(Duration) 1 yrs. .... mos. 1 ds.

(Signed) Robert L. Hunt M. D.

5/17/23, 191... (Address) 3126 Hartford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE. (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL. May 18 1923

20-UNDERTAKER Daniel Eyler

ADDRESS 916 Ba. ave

Cause of death to be printed, as near as may be, in space provided. Important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

D75856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75856

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME Molly Cook

(a) RESIDENCE NO. 22 Canal St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred unknown How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laundress

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 1923 Robert P. Merryman, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to May 16, 1923, that I last saw him alive on May 16, 1923, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary general; acute Apoplexy, Uremia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Gangrene Arm

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of May 16-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arnold Mayloff, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL 5-19 1923

20 UNDERTAKER Daniel Carter

ADDRESS 916 Pine

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcic Infection

Spec. 1-10-21—MAT—1500 Blks.

D75857

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D75857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1927 E 30th (ST.) 9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Isaac Hay.

(a) RESIDENCE No. 1927 E 30th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Annabelle Hay.

6 DATE OF BIRTH (month, day, and year) Oct-8-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist (Retired) Occupy

(b) General nature of industry, business, or establishment in which employed (or employer) ..

(c) Name of employer Self. 825

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Maryland.

PARENTS

10 NAME OF FATHER Louis Hay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Grover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Annabelle Hay 1927 E. 30th St.

15 Filed 1929 Robert F. Garrison Registrar

17 1929 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Jany ..., 1918, to May 16 ..., 1923,

that I last saw h in alive on May 13 ..., 1923,

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

(duration) Sudden. yrs. mos ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5/18/23
20 UNDERTAKER	ADDRESS
H E Stughes	4th & Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75858

CERTIFICATE OF DEATH.

161-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 St. Barnabas Court (WARD) 17

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Groom

(a) RESIDENCE NO. 915 St. Barnabas Court WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17, 1923

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min. 1/2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER August May

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Alice Groom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Mother

15 Filed ..... 19 .....

Robert F. HARTIGAN, Registrar

171923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to May 17, 1923, that I last saw h/m alive on May 17, 1923 and that death occurred, on the date stated above, at 10:00 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(31 Wks)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Norwood Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-18-23
20 UNDERTAKER Daniel Easton	ADDRESS 96 Ca ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.R.R.S.—400 Blks.

D75859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 124

City of BALTIMORE: (No. 1705 W Lafayette Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel D. Chesley

(a) Residence No. 1705 W Lafayette St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ? 1850

7-AGE. 73 yrs. mos. ds.

If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Allegany Co Md

PARENTS.

10-NAME OF FATHER. Dr Nathaniel Chesley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Geo. A. Chesley (Address) 1009 Poplar Grove St.

15- Filed 1923 Robert P. Garrison, 19 Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 17 1923

17. I HEREBY CERTIFY, That I attended deceased from May 5 1923, to May 17 1923

that I last saw him alive on May 17 1923

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Chr interstitial nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Uraemia & P.S.

(Signed) Homer C Todd M. D.

5/17. 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. May 19 1923

20-UNDERTAKER. John O Mitchell

ADDRESS 120 W Lafayette

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D75860

1-PLACE OF DEATH — Registered No.

City of BALTIMORE (No. 2408 Reisterstown Road 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dr John D. Fiske

(a) Residence No. 2408 Reisterstown Road Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 4 1853

7-AGE. 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Physician
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). N.Y.

PARENTS.

10-NAME OF FATHER. Theophelus Fiske

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N.Y.

12-MAIDEN NAME OF MOTHER. Susan Dimmelle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). N.Y.

14- (Informant) Agnes H. Fiske
(Address) 2408 Reisterstown Rd

15- Filed 1923 Robert P. Garrison, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 17 1923

17- I HEREBY CERTIFY, That I attended deceased from ..., 1920, to May 17, 1923, that I last saw him alive on May 17, 1923, and that death occurred, on the date stated above, at 11.10 a. m.

The CAUSE OF DEATH* was as follows:

Abscess of Lung
(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? 2 years ago Lung abscess opened

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank M Fiske M. D.

May 17 1923 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New York N.Y. DATE OF BURIAL, May 19, 1923

20-UNDERTAKER. John C Mitchell ADDRESS 120 W Fayette St

...ied. Exact statement of OCCUPATION is very import... ...in plain terms, so that it may be properly classified. ...instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*) For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Not tubercular

Spec.—1-10-21—M&T—1500 Bks.

D75861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75861

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 W. Lanvale St. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Burke

(a) RESIDENCE No. 2009 W. Lanvale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Burke

6 DATE OF BIRTH (month, day, and year) Feb. 9." 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Peter J. Burke

(Address) 2009 W. Lanvale St.

15 5/17 1923, 19 Robert F. Garrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15" 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to May 15, 1923, that I last saw her alive on May 15, 1923, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Breast

2

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. O'Neill M. D.

5/16 19 23 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	May 18 1923
19 UNDERTAKER Joseph B. Cook	ADDRESS 1063 N. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75862 D75862

CERTIFICATE OF DEATH.

1-PLACE OF DEATH General German Aged Home REGISTERED NO. 129

CITY OF BALTIMORE. (No. 1 E Cor Baltimor Payson ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Antonie Lievs

(a) RESIDENCE. (Usual place of abode) No. 1 E Cor Baltimor Payson ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Herman Lievs

6 DATE OF BIRTH (month, day, and year): March 3, 1834

7 AGE: Years 89 Months 1 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pilsen Switzerland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Records of German Aged Home Balto Payson St

MAY 17 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to May 16th, 1923, that I last saw h[illegible] alive on May 14th, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) John Hoff, M. D.

. 19 (Address) 1843 N Bolto. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 18 1923
20 UNDERTAKER	ADDRESS
Joseph B Cook	1003 N. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D75863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75863

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2011 Clifton Ave. St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeannette Lee Dougherty

(Residence in Baltimore: No. 2011 Clifton Ave. St; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. February 7th (Month) (Day) 1887 (Year)

7-AGE. 36 yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George W. Dougherty

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Georgianna Dunn

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgianna Dougherty

(Address) 2011 Clifton Ave.

15- Robert P. Harrison,

Filed 19 Burial Permit Clerk Registrar.

MAY 17 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 16" (Day), 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Kenney M. D.
(Coroner.)

May 17 192 3 (Address) 2302 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Olivet Cem	May 19 1923
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite statements are insufficient. Name of contagious disease is very important. See instructions on back of certificate.

Apvd. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75864

CERTIFICATE OF DEATH. 122-001 D75864

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 S. Charles St. ST. 23 WARD)

2-FULL NAME John Lawrence Carmody

(a) RESIDENCE NO. 1723 S. Charles St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie E. Carmody

6 DATE OF BIRTH (month, day, and year) Mch. 15" 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
68	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John F. Carmody

(Address) 3610 O. St. N.W. Washington

MAY 17 1923 Robert F. Harrison, 19

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16" 19 23

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19 23, to [illegible] 19 23.

that I last saw h[illegible] alive on [illegible] 19 23.

and that death occurred, on the date stated above, at 9.35 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Liver

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

5/16 19 23 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oella Md.

DATE OF BURIAL 5/18 1923

20 UNDERTAKER Jos. B. Cook

ADDRESS 1003 W. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Alcoholic

Spec.—1-10-21—M&T—1500 Blks.

D75865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75865

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 N. Patterson Pk. Ave. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Franklin Spry

(a) RESIDENCE No. 610 N. Patterson Pk. Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9" 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER David W. Spry

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Evelyn G. Gill

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs. Evelyn Spry

(Address) 610 N. Patterson Pk. Ave.

15 Filed MAY 17 1923 19 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16" 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 27. 1923. to May 16. 1923.

that I last saw him alive on May 16. 1923.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Emfysema.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May. 10/23

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

5/16 1923 (Address) 1823 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	May 18 1923
20 UNDERTAKER	ADDRESS
Jas. B. Cook	1089 W. Balto.

M. B.—Write plainly in ink. Information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D75866

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hanna Mister

(a) RESIDENCE NO. Bay View Hospital ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1827

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	95			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Robert Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Isabella Train

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Municipal Hospital Records
(Address)

Robert E. Harrison,
1923 .19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to May 17, 1923, that I last saw her alive on May 16, 1923, and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? at Hospital

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) A. McGinley, M. D.

5-17-1923 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fremont DATE OF BURIAL May 19 1923

20 UNDERTAKER W. J. Cook ADDRESS 502 E. North

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Riley

D75867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75867

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 133 West North Ave ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonino Badali

(Residence in Baltimore: No. 133 West North Ave

St.; yrs. 32 ~~mos.~~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 26, 1858
(Month) (Day) (Year)

7-AGE, 64 yrs. 9 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Storekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER, Petro Badali

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Ciofalo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carolina Badali

(Address) 122 W. North Ave.

15- Robert P. Garrison,

Filed ....., 191.... Registrar.

17923 Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv dis. Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) ....yrs. ....mos. ....ds.

(Signed) M. D.
(Coroner)

May 17, 1923 (Address) 1659 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, May 18, 1923

20-UNDERTAKER, Wm. Cook — ADDRESS 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Riley - ✓

D75868 HEALTH DEPARTMENT—CITY OF BALTIMORE D75868

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH (or on way to) CITY OF BALTIMORE (No. Mercy Hospital ST. 3 WARD) Registered No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George D. Scott.

(Residence in Baltimore: No. Unknown St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day) (Year)

7-AGE, About 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bricklayers Union #1 Balto

(Address) 201 N. Gay St.

15-

Filed Nov. 2, 1912 Registrar.

N. B.—Every effort should be taken to secure, and every space properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

171923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, about May 13 (Month) (Day), 1912 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dil. Heart

Duration (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

May 17, 1912 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For ~~HOSPITALS~~, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, May 13, 1923

20-UNDERTAKER Wm. Cook ADDRESS 502 E. North

Spec.—1-10-21—M&T—1500 Blks.

75869 D75869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 D75869

1-PLACE OF DEATH St Vincents Infr Asy. REGISTERED NO.....

CITY OF BALTIMORE: (No. 1401- division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Breighner

(a) RESIDENCE NO. St Vincents Inf Asylum ST., WARD Hanover Pa
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 3-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Stanislaus Breighner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Elise Sprenkler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Stanislaus Breighner
(Address) Hanover Pa

15 MAY 18 1923 ROBERT R. KRANTZ, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 22 .1923. to May 17 .1923.
that I last saw him alive on May 17 .1923
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

Bronchio pneumonia (duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. L. Goldsborough, M. D.

, 19 (Address) 2705 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover Pa — DATE OF BURIAL May 18 1923

20 UNDERTAKER Henry W. Myers & Son — ADDRESS 605 N Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75870

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D75870

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 1504 Mount St., Gough St 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mons Morrison

(Residence in Baltimore: No. 1504 Gough St.; yrs., 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): M

6-DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7-AGE: 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Russia

PARENTS:

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1434 E Baltimore St

Filed MAY 18 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Consumption

(Duration) yrs. mos. ds.

(Signed) Geo Edmonds Radcliffe M. D.
(Coroner)

May 23 19.. (Address) 143 N Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Rodeph Shalom — DATE OF BURIAL: May 18 1923

20-UNDERTAKER: Jack Lewis — ADDRESS: 1434 E Baltimore St

N. B.—Every item of information should be carefully ascertained. If may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be certificate. is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Pfannkuchen

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 3536 D75871

32 D75871

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 ST., WARD)

2-FULL NAME Vernon Pfannkuchen

(a) RESIDENCE NO. 613 N. Curley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Otto Pfannbuckeg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Magaret Haffner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 MAY 18 1923 ROBERT A. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1923, to May 17, 1923, that I last saw him alive on May 17, 19..., and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? T.B. bacilli in spinal fluid

(Signed) Horton Casparis M. D.

19 (Address) JOHNS HOPKINS HOSP.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Ave

DATE OF BURIAL May 21 1923

20 UNDERTAKER John Ellicott

ADDRESS 2008 Eutaw.

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Tomaravckas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75872

CERTIFICATE OF DEATH.

90

D75872

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. at or near 602 E. Pratt St. Ward) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Raphael Tomaravckas

(Residence in Baltimore: No. 429 N. Bridge St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. ..... 1.....
(Month) (Day) (Year)

7-AGE. 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS:

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Tamas

(Address) 429 N. Bruce St.

15-Filed MAY 18 1923, 192

ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner)

May 18, 192 (Address) 765 Cathedral

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St. Stanislaus May 19, 1923

20-UNDERTAKER. ADDRESS

John Gelbiunas 425 S. Paca St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—MAT—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75873

CERTIFICATE OF DEATH.

151 D75873

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 Esther Place ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia R. Pfeifer

(a) RESIDENCE NO. 2634 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND (or) WIFE of John Pfeifer

6 DATE OF BIRTH (month, day, and year) Oct. 12/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	73	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work St. Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Pfeifer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Pfeifer (Address) 2634 E. Oliver St.

15 MAY 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from February, 1920, to May 17, 1923, that I last saw h[er] alive on May 16, 1923, and that death occurred, on the date stated above, at 12.20 A m.

The CAUSE OF DEATH* was as follows:

1 Senile Gangrene of both lower extremities (duration) 3 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

May 17 1923 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 5/19 1923

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans St.

BEFORE SIGNING BE CERTAIN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75874

CERTIFICATE OF DEATH.

60-002 D75874

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2432 E. Fayette ST., 6 WARD)

2-FULL NAME Jacob Haensler

(a) RESIDENCE NO. 2432 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna M. Haensler

6 DATE OF BIRTH (month, day, and year) Sept 24/61

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) Agent

(c) Name of employer Metropolitan Ins Co

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Frederick Haensler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M. Haensler

(Address) 2432 E. Fayette

15 MAY 18 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April 22 1923, to May 16 1923, that I last saw him alive on May 14 1923, and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertrophoidism

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) Wm J. Gillbuty, M. D.

, 19 (Address) 1415 Cedarcroft Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem — DATE OF BURIAL May 19 1923

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75875

CERTIFICATE OF DEATH.

90 D75875

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Byrd St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Hull.

(a) RESIDENCE NO. 1710 Byrd St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Marian Hall.

6 DATE OF BIRTH (month, day, and year) December 19th. 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brakesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George L. Hull.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Margaret Essen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Marian Hull. (wife)
(Address) 1710 Byrd St.

15 FILED MAY 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

May 17th. 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer Cem. DATE OF BURIAL May 19 1923

20 UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light

IMPORTANT is very important. See instructions on back of certificate.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75876

CERTIFICATE OF DEATH.

41 D75876

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Park Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Barnitz Phelps

(a) RESIDENCE No. 1725 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Hart Phelps

6 DATE OF BIRTH (month, day, and year) Aug 18 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home miss

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Frank J Barnitz

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Ray H. Simmons

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) New Orleans, La. Prob.

14 Informant Frank Hart Phelps
(Address) 1725 Park Ave

15 MAY 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 14, to May 16, 19 23.

that I last saw her alive on May 5 19 23.

and that death occurred, on the date stated above, at 4.35 am.

The CAUSE OF DEATH* was as follows:

Lymphadenosis of undetermined origin

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Infarct (Rt)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Two blood counts showing multiple abnormal lymphocytes. Histopathological Laboratory.

(Signed) Chas C Bond M. D.

19 (Address) 1701 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Mem

DATE OF BURIAL May 18 1923

20 UNDERTAKER H W Jenkins & Sons Co

ADDRESS McCulloh & Orchard

Spec.—1-10-21—M&T—1500 Blks.

D75877 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H-f D75877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Gutowski

(a) RESIDENCE NO. 822 S. Bond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Gutowski.

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Paul Gutowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rose Polatowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Municipal Hospital Records.

(Address)

Filed MAY 18 1923 . 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 11, 19 23, to May 16, 19 23,

that I last saw him alive on May 16, 19 23,

and that death occurred, on the date stated above, at 3:55 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Insanition

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) A. M. Shipley, M. D.

5-17-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL May 19 1923.

20 UNDERTAKER M. F. Sadowski. ADDRESS 905 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

D75878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D75878

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 723 S. Bond ST., 2 WARD)

2-FULL NAME Catherine Goralski

(a) RESIDENCE NO. 723 S Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 33 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Goralski.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Houses work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Anthony Goralski
(Address) 2707 Dalton St

15 MAY 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1 1923, to May 16 1923, that I last saw her alive on " 10 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) C. A. Neer, M. D.

5/16/23 (Address) 408 N Patterson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	5/19-1923
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75879

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D75879

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2507 St, Paul ST. 12 WARD)

2-FULL NAME Victoria A. McKillan

(a) RESIDENCE NO. 2507 St, Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore McKillan

6 DATE OF BIRTH (month, day, and year) Oct, 3, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wheeling
(State or country) W. Va.

PARENTS

10 NAME OF FATHER Thomas MacLachlan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Eliza A. Robinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Samuel H. McKillan
(Address) 2507 St. Paul St.

15 Filed MAY 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22 1923 to May 16th 1923.

that I last saw her alive on May 16th 1923.

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Epithelioma of the left breast

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 21st 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Fair M. D.

5/17 1923 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	5/18 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75880

CERTIFICATE OF DEATH.

90 ✓ D75880

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N. Castle ST., 6 WARD)

2-FULL NAME August Sattler

(a) RESIDENCE NO. 16 N. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE) Josephine Sattler

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Filing Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Ind. Casualty Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Cora Antman

(Address) 7842 S. Curley St

15 MAY 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15/ 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec (about), 1922, to May 15, 1923.

that I last saw him alive on May 15, 1923,

and that death occurred, on the date stated above, at 10 15 p m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation - Dilatation

(about) (duration) 3 yrs. — mos. — da.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) — yrs. — mos. 14 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. E. Rader, M. D.

, 19 (Address) 1904 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 19 1923
20 UNDERTAKER	ADDRESS
Wendell Apple & Son	3781

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75881

CERTIFICATE OF DEATH.

90 D75881

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3708 Old Frederick Rd. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dietrich Schott

(a) RESIDENCE NO. 3708 Old Frederick ST., Rd WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sofie Schott

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

017

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dietrich Schott

(Address) 3708 Old Frederick Rd

15 FILED MAY 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1918, to May 16, 1923

that I last saw him alive on May 15, 1923

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Old Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

5 17 1923 (Address) Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL May 19, 1923

20 UNDERTAKER L. W. Dill — ADDRESS 3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75882 — 129 — D75882

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 Hutchins ave ST.: Grus WARD 27)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Wafford.

(a) RESIDENCE. No. 426 Hutchins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 24 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Elk Hill
(State or country) Virginia

PARENTS

10 NAME OF FATHER Richard Wafford.

11 BIRTHPLACE OF FATHER (city or town) Elk Hill
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emily Wren.

13 BIRTHPLACE OF MOTHER (city or town) Elk Hill
(State or country) Virginia

14 Informant Emily Wafford Gross
(Address) 426 Hutchins ave

15 Filed MAY 16 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April - 1, 1923, to May - 16, 1923, that I last saw him alive on May - 15 - 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Koons, M. D.

4-17. 1923 (Address) 6600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	5-19 1923

20 UNDERTAKER George W. Hollaway

ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

- 129 ✓

D75883

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 School ST., 15 WARD)

2-FULL NAME Wm H. Jones

(a) RESIDENCE NO. 705 School ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 3-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or estsblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Lora Gail

(Address) 725 School Lane

15 Filed MAY 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17 1923

17

I HEREBY CERTIFY, That I attended deceased from 1/2, 1923, to 5/17, 1923,

that I last saw h alive on 5/17, 1923,

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chr. Nephritis

(duration) yrs. 4 mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burk Bullen, M. D.

5/17 1923 (Address) 2139 Dill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 20 23
20 UNDERTAKER George H. Holland	ADDRESS 1631 Div Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1000 Blks.

D75884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75884

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 E. Chase St ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) 1, Pm

2-FULL NAME William A. Leitch

(a) RESIDENCE NO. 1408 E. Chase (Usual place of abode) ST., WARD

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds. (If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary W. Leitch

6 DATE OF BIRTH (month, day, and year) Feby 2, 1846

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank Teller

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Bank of Balt

9 BIRTHPLACE (city or town) Mt Pisgah (State or country) Missouri

PARENTS

10 NAME OF FATHER John F. Leitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Rachel Armiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co. Md

14 Informant Mary Williams Leitch (Address) 1408 E. Chase St.

15 MAY 18 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1923, to May 17, 1923, that I last saw h— alive on May 17, 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Aortic Reg. Dilated Heart and Cardiac Asthenia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? O

Did an operation precede death? O Date of

Was there an autopsy? O

What test confirmed diagnosis? O

(Signed) R. H. Davis, M. D.

, 19 (Address) 1509 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL May 19 1923

20 UNDERTAKER John B. Spence — ADDRESS 1325 N Eutaw St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75885 — CERTIFICATE OF DEATH. — 57 D75885

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Provident Hospital ST., 8 WARD)

2-FULL NAME Isaac Jones

(a) RESIDENCE NO. 1733 Carlisle Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jones

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va. (State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Mary Dorsey (Address) 1733 Carlisle Place

15 MAY 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22nd, 1923, to May 15th, 1923.

that I last saw him alive on May 14th, 1923

and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene of Rt Foot (duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary Test

(Signed) Harry F. Brown, M. D.

5/25/1923 (Address) 501 Pressman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 18 1923
20 UNDERTAKER Wm. R. G. Elliott	ADDRESS 1127 E. Baltimore

Information should be correctly supplied. Exact statement of OCCUPATION should be stated. Note that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75886

CERTIFICATE OF DEATH. X 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 E 23 dd. ST., 17 WARD)

2-FULL NAME Minnie Brown

(a) RESIDENCE NO. 417 E 23 dd ST., WARD S. 6.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Brown.

6 DATE OF BIRTH (month, day, and year): 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
28				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Johnston S. C.

PARENTS

10 NAME OF FATHER: Wm Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Mary Lomax

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant (Address): Joseph Brown husband 417 E 23 St

15 Filed MAY 18 1923 ROBERT R. KRAMER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9th. 1923. to May 17th. 1923.

that I last saw h[illegible] alive on May 16th. 1923.

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Emphysema following Lobar Pneumonia

(duration) yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos 2 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

, 19 (Address) 417 E 23 dd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edgefield Cem. J. V. C.	May 22 1923
20 UNDERTAKER	ADDRESS
M. H. C. Elliott	1123 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D75887

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 Otterbein ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll McComisie

(a) RESIDENCE NO. 312 Otterbein ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col,	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md,

PARENTS

10 NAME OF FATHER James McComisie

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?)

12 MAIDEN NAME OF MOTHER Sarah Lawyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Sarah Lawyer

(Address) 312 Otterbein St

15 MAY 18 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15th, 1923, to May 17, 1923, that I last saw him alive on May 16, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(following Whooping Cough)

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. K. Carroll, M. D.

5/18, 1923 (Address) 140 W Hill st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 5/18 1923

20 UNDERTAKER Mrs Geo. H. Hooper — ADDRESS 406 Conway St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75888

CERTIFICATE OF DEATH.

129

D75888

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2707 Alameda Boulevard ST., 9 WARD)

2-FULL NAME Margaret Scherer

(a) RESIDENCE NO. 2707 Alameda Boulevard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip H. Scherer

6 DATE OF BIRTH (month, day, and year): Mar 15 1877

7 AGE: Years 46; Months 2; Days 2; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles H. White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Long Island

12 MAIDEN NAME OF MOTHER: Sophia Bent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Philip H. Scherer

(Address) 2707 Alameda Boulevard

15 MAY 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17th 1923

17

I HEREBY CERTIFY, That I attended deceased from January, 1922, to May 16, 1923.

that I last saw her alive on 5/16/23., 19....,

and that death occurred, on the date stated above, at 17 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Ulcerative Pulmonary Tuberculosis

Acute Stenosis

(duration) 3-4 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic etc

(Signed) John J Alexander, M. D.

. 19 (Address) 562 Keyser Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 5/19/1923

UNDERTAKER: Chas E. Evans & Son

ADDRESS: 111 North Royal Ave

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75889

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH D75889

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fountain Allen

(a) RESIDENCE No. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) N/G

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed MAY 18 1923 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to May 13, 1923, that I last saw him alive on May 12, 1923, and that death occurred, on the date stated above, at 4:45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Mouth

(duration) 1 yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D.

5-14-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

MAY 18 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75890

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 302 B. St. (Roland Park) ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Desmond Stinfield Parker

(Residence in Baltimore: No. 302 B. St. Roland Park. St.; yrs., 5 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov. (Month) 21 (Day), 1922 (Year)

7-AGE, — yrs. 5 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Newton B. Parker

11-BIRTHPLACE OF FATHER (State or Country) Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Hazel E. Kleinfelter

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Newton B. Parker

(Address) 302 B. St. Roland Park

15-

Filed MAY 18 1923 Robert P. Harrison, M.D. Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 17 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis a

Pneumonia

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Thos. H. Verdi M. D. (Coroner.)

May 19, 1923. (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, May 19, 1923.

20-UNDERTAKER Horace F. Burgee — ADDRESS 631 Falls Road

Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75891

CERTIFICATE OF DEATH.

83 D75891

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1113 E. 37th St. (ST.,) 13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Schneiwohl

(a) RESIDENCE (No.) 1113 E. 37th St. (ST.,) 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schneiwohl

6 DATE OF BIRTH (month, day, and year) March 22-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	72	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor Pa. R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 9 years

(c) Name of employer

9 BIRTHPLACE (city or town) York (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Schneiwohl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elizabeth Schneiwohl

(Address) 1113 E. 37th St.

15 Filed MAY 18 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923.

17 I HEREBY CERTIFY, That I attended deceased from 5-11, 1923, to May 17, 1923

that I last saw h— alive on May 17, 1923

and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Softening

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Senl Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) C. H. Humpbell, M. D.

5-18, 1923 (Address) 3701 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 21, 1923.
20 UNDERTAKER Horace H. Burgee	ADDRESS 3631 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75892

CERTIFICATE OF DEATH.

D75892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 9 WARD)

REGISTERED NO. 126

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Davidson

(a) RESIDENCE No. Emer - Back River ST., WARD Essex Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of
~~or WIFE of~~ Caroline E. Davidson

6 DATE OF BIRTH (month, day, and year) Feb-2-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9 BIRTHPLACE (city or town) Laurel Md
(State or country)

PARENTS

10 NAME OF FATHER Davidson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Caroline E. Davidson
(Address) Essex Balto Co

15 Robert F. Harrison,
Registrar

18 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to May 17, 1923, that I last saw him alive on May 17, 1923 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Pneumococcic peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 5-16-23

Was there an autopsy? Not

What test confirmed diagnosis? Operation-Culture.

(Signed) J. V. Szczerbicki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	5/20 1923
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

(Outer)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75893

CERTIFICATE OF DEATH.

X 101-001 D75893

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Owton

(a) RESIDENCE NO. Marion. Md. ST., WARD Marion Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	15	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Jolly Owton.

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Ellen —

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant W. H. Jamury

(Address) 205 Vickers Bldg

15 MAY 18 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/15 1923 to 5/17 1923; that I last saw h[illegible] alive on 5/11 1923, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

Carcinoma Duodenum ?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Leon Friedman, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohrlsfield Md — DATE OF BURIAL 5-19 1923

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAT—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75894

CERTIFICATE OF DEATH.

84 D75894

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 N. Bruston ST., 11 WARD)

2-FULL NAME Bernhard Bowen

(a) RESIDENCE NO. 302 W. Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Bowen

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Jessie Rich

13 BIRTHPLACE OF MOTHER (city or town) La
(State or country)

14 Informant Jessie Bowen
(Address) 302 W. Preston St

15 Filed Robert F. Harrison, Registrar
1 8 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18-1923

17 I HEREBY CERTIFY, That I attended deceased from 5-10-23, 19..., to 5-18-23, 19...,

that I last saw h.. alive on ..., 19...,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:

Rachitis

(duration) yrs. 5 mos. 2 ds.

CONTRIBUTORY (Secondary) Marasmus, hydrocephalus

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. A. Cardegno, M. D.

, 19 (Address) 1524 Dillwyn Alley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: B.M. Cemetery Co

DATE OF BURIAL: 5-19-1923

20 UNDERTAKER: Bond Taylor

ADDRESS 916 Eutaw

mation should be carefully supplied. Note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75895

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Kreamer

(Residence in Baltimore: No. 415 S. Chapel St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	single

6-DATE OF BIRTH. April 8/1919 (Month) (Day) (Year)

7-AGE. 4 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. James Kreamer

11-BIRTHPLACE OF FATHER, (State or Country). Balt. Md.

12-MAIDEN NAME OF MOTHER. Bertha Copper

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Kreamer

(Address) 415 S. Chapel

15- Filed MAY 19 1923 Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- 2nd & 3rd degree burns over abd. & chest & neck- Clothing caught fire while playinh with matches & punk.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Patter M. D. (Coroner.)

5/18/23 192.... (Address) 500 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oakland	5/19 1923
20-UNDERTAKER.	ADDRESS.
Wm Cook	502 E Fish Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D75896 12827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75896

CERTIFICATE OF DEATH.

52

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 17 WARD)

2-FULL NAME William Anthony

(a) RESIDENCE NO. 511 W. Biddle St. ST., City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Maggie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Johns Hopkins Hospital

Informant

(Address)

15 Filed , 19 Robert F. Garrison, Burial Permit Clerk. Registrar

19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to May 16, 1923, that I last saw h alive on May 16, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation in Chr. Rheumatic Heart.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Rheumatic fever

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirm

(Signed) M. D.

, 19 (Addr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL May 19 1923

20 UNDERTAKER Samuel J. Kennedy

ADDRESS 576 N. Bid

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75897

CERTIFICATE OF DEATH.

129 D75897

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 511 Woodbourne ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Garraway

(a) RESIDENCE. NO. 571 Woodbourne ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Garraway

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) Refining Sugar

(c) Name of employer Expert Co

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Phebe Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Isaac Garraway
(Address) 571 Woodbourne Ave

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1923, to May 16, 1923, that I last saw h alive on May 16, 1923, and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease. Contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) R. Garland Cabell M. D.

May 17 1923 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westwood | DATE OF BURIAL: 5/19 1923

20 UNDERTAKER: Samuel T. Rogers | ADDRESS: 578 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75898

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75898

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 N. Bethel ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Havelka

(a) RESIDENCE NO. 1509 N. Bethel ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. — mos. — ds. How long in U. S., if of foreign birth? 31 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced (or) WIFE of Carl Havelka

6 DATE OF BIRTH (month, day, and year) February 18th 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Mr. - Bloecher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not. Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Carl Havelka (Address) 1509 N. Bethel St.

15 Filed Robert P. Harrison Registrar

191923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17

I HEREBY CERTIFY, That I attended deceased from March 28. 1923 to May 19. 1923.

that I last saw her alive on May 18. 1923

and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Paralysis agitans

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) F. J. Sebold, M. D.

, 19 (Address) 1001 Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL May 21 1923

20 UNDERTAKER Henry Hoech & Son ADDRESS 1301 E. Eager St.

IMPORTANT—Should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D75899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 W. Churdh St. ST., 22 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Naoma Turner.(C)

(a) RESIDENCE No. 725 Brannan Court. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Turner.(C)

6 DATE OF BIRTH (month, day, and year) July 10th. 1890.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Butler.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sallie Fassett.C

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Joseph Turner.(C)husband.
(Address) 725 Brannan Court.

15 Robert F. [illegible] , 192 .....
Registrar

MAY 19 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Sign) Otto M Reinhardt, M. D.
(Coroner.)

May 17th. 192 3 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — DATE OF BURIAL may 19 1923

20 UNDERTAKER Edward Brogan — ADDRESS 631 Lemmon St

Information should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75900

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D75900

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1534 Orleans ST. 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alberta Keene

(Residence in Baltimore: No. 1534 Orleans St.; 16 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If single, write the word): Single

6 DATE OF BIRTH: March 30th, 1907 (Month) (Day) (Year)

7 AGE: 16 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Bamberg, Ind

PARENTS

10 NAME OF FATHER: Mr. J. Keene

11 BIRTHPLACE OF FATHER (State or country): Dorchester Co, Md

12 MAIDEN NAME OF MOTHER: Blanche Molondy

13 BIRTHPLACE OF MOTHER (State or country): Dorchester Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. J. Keene

(Address) 1534 Orleans St.

15 Robert P. Harrison, 191 REGISTRAR

Burial Permit Clerk.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

191923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 17th, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1923, to May 17th 1923, that I saw her alive on May 16th, 1923, and that death occurred, on the date stated above, at 4 P. m. The CAUSE OF DEATH* was as follows:

Acute miliary Tuberculosis

(Duration) yrs. 1 mos. 1 ds

Contributory (SECONDARY): Exhaustion

(Duration) yrs. mos. 4 ds.

(Signed) P E Gilpin M. D.

May 15th, 1923 (Address) 1534 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodberry cemetery — DATE OF BURIAL: May 21, 1923

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 Orleans St

Spec.—1-10-21—M&T—1500 Blks.

D75901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75901

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Garrison Av ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W Schultz

(a) RESIDENCE No. 3704 Garrison Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Schultz

6 DATE OF BIRTH (month, day, and year) July 5 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Christian Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Chas. Schultz

(Address) Paca & Fulton Ave

15 Filed MAY 19 1923 16 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 1 1922 to May 16 1923.

that I last saw him alive on May 16 1923,

and that death occurred, on the date stated above, at 5-P.M.

The CAUSE OF DEATH* was as follows:

Diffuse nephritis

Mitral Regurgitation

(duration) 1 yr. mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 3 dy

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Metzel M.D.

May 17 1923 (Address) 1903 W. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 19 1923

20 UNDERTAKER M. C. Tschner & Sons — ADDRESS Paca Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given. Words like Laborer, Clerk, Housewife, etc., alone are indefinite and insufficient. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D75902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 22 WARD)

REGISTERED NO. 1883

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Feoreno.

(a) RESIDENCE NO. 20 E. York St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 9 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 13, 1918.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	9	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Feoreno.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Josephine Farinato.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Samuel Feoreno. (father).
(Address) 20 E. York St.

MAY 19 1923 Filed ....., 192 Robert F. Carrison, Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally run over by automobile,
No. 84-274. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Fernbandt (Coroner.), M. D.

May 18, 1923 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? York St. near Light St. May 17, 1923.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery A A Co. DATE OF BURIAL May 19 1923

20 UNDERTAKER John F Denny ADDRESS 715 Light St

CAUSE OF DEATH should be properly certified. Read instructions on back of certificate.
TION is very important. See instructions on back of certificate.

D75903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75903

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2214 Brunt St St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. David A Gray

(Residence in Baltimore: No. 2214 Brunt St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 14th, 1864
(Month) (Day) (Year)

7-AGE, 59 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), St Marys Co Md

PARENTS.

10-NAME OF FATHER, Leonard Gray

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co

12-MAIDEN NAME OF MOTHER Rhoda Tenn

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felicia Gray

(Address) 2214 Brunt St

15- May 17, 1933

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

191923

N.B. Every line of information should be carefully supplied. Exact statement of OCCUPATION is necessary to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1933
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Automobile Fracture

(Duration) yrs. mos. 1/4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

....., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, May 19th, 1933

20-UNDERTAKER Samuel Wright

ADDRESS 2569 Mary

D75904 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75904

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View— 3 Registered No. C.....

City of BALTIMORE: (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Swift

(Residence in Baltimore: No. 3135 Bond St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March 30, 1892
(Month) (Day) (Year)

7-AGE. 31 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Charles Swift

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary Swift

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate Swift

(Address) 3135 Bond St.

15- Filed ..... 192.. Robert F. Harrison, Registrar.

19 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 17½ 192..3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Interval Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Jumped out 3rd Story Window at 1st Pres.

(Duration) ... yrs. ... mos. ... ds.

(Signed) ..... Coroner ..... M. D.

May 18 192.3 (Address) Baltimore City

*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenlawn	May 19, 192.3

20-UNDERTAKER.	ADDRESS
Randall Cypress	376 Lan

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75905

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 W. Saratoga St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Walker

(a) Residence No. 711 W. Saratoga St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of [redacted] Ida Walker

6-DATE OF BIRTH (month, day and year) 1932

7-AGE. 91 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Penn Dee

PARENTS

10-NAME OF FATHER, James J Walker

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Penn

12-MAIDEN NAME OF MOTHER, Anna Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Penn

14- (Informant) Tom Walker

(Address) 706 Waterloo St

15- Robert F. Harrison, M.D. Registrar.

19 1923

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 17, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1923 to May 17, 1923

that I last saw him alive on May 17, 1923

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Polyuria Test

(Signed) John R Lecky M. D.

, 19 (Address) 753 Gough

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon — DATE OF BURIAL, May 20. 1923

20-UNDERTAKER. R B Gross — ADDRESS 1405 McElderry St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75906

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3601 Forrest Park St., 19th WARD)

2-FULL NAME Clara Ring Smith

(a) RESIDENCE NO. 3601 Forrest Park St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Smith

6 DATE OF BIRTH (month, day, and year) Jany 9 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Moses Ring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Siegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Wm. M. Ring

(Address) 3601 Forrest Park Ave

15 Robert P. Harrison, .19 Registrar

Burial Permit Clerk

191923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/1923.

17

I HEREBY CERTIFY, That I attended deceased from Jan. .1923, to May .1923,

that I last saw he alive on May 18 .1923,

and that death occurred, on the date stated above, at 2.10 P m.

The CAUSE OF DEATH* was as follows:

arteris-sclerosis (hypertension)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy (cerebral hemorrhage) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz, M. D.

.19 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fellowship Friendship 5/20/1923

DATE OF BURIAL

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 lbs.

D75907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D75907

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Ft. Mulberry ST., 17 WARD)

2-FULL NAME Wm Lee

(a) RESIDENCE NO. 706 Ft. Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Roberta Lee

6 DATE OF BIRTH (month, day, and year) March 7, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Porter

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm Lee

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Phillips

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Roberta Lee
(Address) 706 N. Mulberry St

15 19 Robert P. Harrison, Registrar

19923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 8th, 1923, to May 17th, 1923, that I last saw h[illegible] alive on May 17th, 1923 and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 6 mos. [illegible] ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Elliott, M. D.

5/18, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 20 1923
20 UNDERTAKER Mrs R. A. Elliott	ADDRESS, 124 Eutaw

REGISTRAR MUST BE CAREFUL to see that all items are properly answered. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75908

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 386 E. 31st St.) (12 WARD)

2-FULL NAME Josie Houston Maynard

(a) RESIDENCE NO. 386 E. 31st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) Married

5a If ~~married~~, ~~widowed~~, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of Raymond Easton Maynard

6 DATE OF BIRTH (month, day, and year) Aug 29 1890

7 AGE — Years 32 Months 8 Days 18 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Littleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sallie Murdock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Raymond C. Maynard
(Address)

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

Y 19123

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 22 to May 17 1923
that I last saw h alive on May 17 1923
and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) H. Eckhard, M. D.

1100 Bluelaw (Address) 5-17-1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Mt Olivet Cem May 19 1923

20 UNDERTAKER — ADDRESS
Chenoweth & Son Chestnut Ave.

BEFORE signing be CAREFUL to see that all items are correctly supplied. Exact statement of OCCUPA-TION should be given. Avoid use of general terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 12-23-21 E B W 6—400 Blks.

D75909

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D75909

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Lepchuk

(a) Residence No. ? China St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1882

7-AGE.	If LESS than 1 day,
40 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Municipal Hospital Record

(Address)

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

0388

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1923 to May 16, 1923

that I last saw him alive on May 15, 1923

and that death occurred, on the date stated above, at 8:35 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. McPowell M. D

5-16 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19....
UNIVERSITY OF MARYLAND	
20-UNDERTAKER, Commissioner Health.	ADDRESS

Print. Wm. K. WOODALL

AY 191923

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75910

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital 20 mos WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Patrick Campbell

(a) RESIDENCE NO. 416 Front Fells WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Campbell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61 yr.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER — Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Campbell 416 Front Ave

15 Filed 19 Burial Permit Clerk. Registrar

191923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1923

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 18, 1923, that I last saw h alive on May 18, 1923, and that death occurred, on the date stated above, at 8:05 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.
Cachexia.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of May 8, 1923

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Edward F. Kidawski, M. D.

19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL May 22, 1923

20 UNDERTAKER C. H. Dill — ADDRESS 3109 Frederick Ave

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75911

D75911

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospl. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mattie Gale

(a) RESIDENCE NO. 639 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Thomas Gale

6 DATE OF BIRTH (month, day, and year) 7-27-41

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	81	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md

PARENTS

10 NAME OF FATHER Jno Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E Jump

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md-

14 Informant Hospital Records

(Address)

Robert P. Harrison,

19 1923 ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18-23

17 I HEREBY CERTIFY, That I attended deceased from 4-10-23, 19..., to 5-18-23 19...

that I last saw h... alive on 5-18-23, 19...

and that death occurred, on the date stated above, at 9 00 a m.

The CAUSE OF DEATH* was as follows:

Ca. Suprarenal Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Compton M. D.

19 (Address) 807 Gunston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Still Pond, Kent Co, Md

DATE OF BURIAL 5/18 1923

20 UNDERTAKER Henry U. Dyers & Son

ADDRESS 805 N Calvert

via Ericson Steamship Line - JULIEN C. GALE - ESCORT

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75912 HEALTH DEPARTMENT—CITY OF BALTIMORE D75912

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1419 Harford Ave St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Fallon

(Residence in Baltimore: No. 1419 Harford Ave St.; yrs. 4y mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.)
male	white	single

6-DATE OF BIRTH, June 26/1889
(Month) (Day) (Year)

7-AGE. 33 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Michael Fallon

11-BIRTHPLACE OF FATHER. (State or Country) Ireland

12-MAIDEN NAME OF MOTHER. Mary McGEE

13-BIRTHPLACE OF MOTHER. (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Fallon

(Address) 1419 Harford Ave

15- Robert P. Harrison, 192.....

191923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17/23, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came this death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Tuberculosis of Mesentery
(At least abdominal)
(Ex- service)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(nactive) (Duration) 2-3 yrs. mos. ds.

(Signed) J. S. Fallon M. D.
(Coroner.)

5/18/23 (Address) 5pl. E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
New Cathedral Cemetery May 21 1923

20-UNDERTAKER. ADDRESS
George J. Ruth 1735 Harford Ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D75913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75913

CERTIFICATE OF DEATH.

REGISTERED NO. 25 1923

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4th Ave & 8th St. Fairfield ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Dirton. (C).

(a) RESIDENCE NO. 7th St. Fairfield. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, widowed, or divorced: HUSBAND of ~~wife of~~ Lucinda Dirton. (C).

6 DATE OF BIRTH (month, day, and year) November 1886.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	6	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Lewis Dirton. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Caroline Choice. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina.

14 Informant: Lucinda Dirton. (C). (wife).
(Address) 7th, St. Fairfield.

15 Robert F. Harrison, ... 192 ... Registrar

Burial Permit Clerk.

1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (inquest, autopsy or inquiry.) inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull, fractured ribs, punctured lungs. Run into by a motor cycle. Homicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto H. Reinhardt, M. D. (Coroner.)

May 18, 1923 (Address) 101 W. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenville S. Carolina — DATE OF BURIAL: 5/19th 1923

20 UNDERTAKER: Chas. H. Alexander — ADDRESS: 826 Druid Hill Ave

Per J. M. Skinner

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Cascio)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75914

CERTIFICATE OF DEATH.

161-001

D75914

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 W Mulberry ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cascio

(a) RESIDENCE NO. 618 W Mulberry St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/17/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Cascio

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Cascio

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Samuel Cascio
(Address) 618 W. Mulberry St.

15 Filed ..... 19 .....
Robert P. Harrison,
Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/1923

17 I HEREBY CERTIFY, That I attended deceased from 5/17/, 1923, to 5/17/, 1923,
that I last saw him alive on 5/17/, 1923,
and that death occurred, on the date stated above, at 10-35 P m.
The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Birth
(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) Thomas J Burke M. D.

5/18/1923 (Address) 407 E. 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	May 19 1923
20 UNDERTAKER Jos B Cook	ADDRESS 1003 E Balto

D75915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓

D75915 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 837 Rabory St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Nancy Maynard

(Residence in Baltimore: No. 837 Rabory st. St.; 24 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	Col.	Married

6-DATE OF BIRTH. ..... Don't Know ..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
24 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarice Maynard

(Address) 837 Rabory st

15- Filed MAY 20 1923 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) 16 (Day) 192.3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

10 months

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

May 18 192.3 (Address) 1127 Hanover st

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	5-21- 19.23
20-UNDERTAKER,	ADDRESS 916
Daniel Easton	Penna ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75916

CERTIFICATE OF DEATH.

100-001

D75916

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N. Mount ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis T. Dyson

(a) RESIDENCE NO. 722 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col'd.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 13, 1920

7 AGE — Years: 2 — Months: 9 — Days: 4 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Eugene Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Ridgley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Eugene Dyson

(Address) 722 N Mount St

15 MAY 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 17, 1923, that I last saw [illegible] alive on May 17, 1923, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos 2 hrs

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. D. Duff, M. D.

5/18, 1923 (Address) 108 N Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 5-21-1923

20 UNDERTAKER: David Easton

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75917

CERTIFICATE OF DEATH.

46 D75917

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 W. Pratt ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Bodenwick

(a) RESIDENCE NO. 1919 W Pratt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Bodenwick

6 DATE OF BIRTH (month, day, and year) Jan 15 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
57	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Peter Bartenbacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William J Bodenwick

(Address) 1919 W. Pratt St.

15 MAY 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to May 18, 1923, that I last saw him alive on May 18, 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

"Cancer"

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. T. Olivet, M. D.

5/19/23 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL May 21 1923

20 UNDERTAKER George L. Schwab — ADDRESS 710 Park Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16374 D75918

HEALTH DEPARTMENT—CITY OF BALTIMORE D75918

CERTIFICATE OF DEATH.

86-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St., V Ward)

2-FULL NAME Sophia Wernick

(a) RESIDENCE NO. 114 S. Chester St St., ... Ward

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath Md

PARENTS

10 NAME OF FATHER Lewis Wernick

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Russia

12 MAIDEN NAME OF MOTHER Rosa Lichenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAY 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17

I HEREBY CERTIFY, That I attended deceased from May 17. 1923. to May 19. 1923.

that I last saw her alive on May 19. 1923.

and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Diarrhea (Not Dysentry)

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? ..... Date of No

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Horton Cooper, M. D.

19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wm Lovegrove Mt. Carmel	5-20-23

20 UNDERTAKER Jack Lewis, ADDRESS 1799 E. Preston

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

807 Catherine St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D75919

REGISTERED NO.

D75919
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Barclay ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Heim

(a) RESIDENCE NO. 2118 Barclay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Dec 25 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	4	22.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS
10 NAME OF FATHER: Ludwig Heim
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.
12 MAIDEN NAME OF MOTHER: Mary Heim.
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. Francis Haberlander
(Address): 2118 Barclay St

15 MAY 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-17 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1921, to May 17, 1923.
that I last saw her alive on May 16, 1923
and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:
Chr. nephritis, Emphysema, arteriosclerosis & hypertension

(duration) 2 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Coronary thrombosis.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes
Did an operation precede death? 0 Date of
Was there an autopsy? 0
What test confirmed diagnosis? 0

(Signed) [illegible], M. D.
5/23 1923 (Address) 804 Catherine St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A.A.C.
DATE OF BURIAL: 5-21 1923

20 UNDERTAKER: E & B Harle 115
ADDRESS: E West St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75920

129 D75920

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1439 Hanover ST., 23rd WARD)

2-FULL NAME Flora M. Sauter.

(a) RESIDENCE No. 1439 Hanover ST., 23rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 52 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Jan. 10 1857

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Earl Sauter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Victoria Hohner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Blandine Sauter

(Address) 1439 Hanover St

15 MAY 20 1923 ROBERT A. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5- 19th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1923. to May 19, 1923.

that I last saw her alive on May 18, 1923

and that death occurred, on the date stated above, at 1/2 3o A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 1 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Harry Leidel M. D.

. 19 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer.

DATE OF BURIAL: 5-22 1923

20 UNDERTAKER: E & B Harle

ADDRESS: 115 E West St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75921

CERTIFICATE OF DEATH.

49

D75921

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Roland Park

CITY OF BALTIMORE: (No. 20 Merrymount Road ST., 27 WARD)

2-FULL NAME Camilla Cromwell Corner

(a) RESIDENCE NO. 20 Merrymount Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~
Female	White	Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of William H Corner

6 DATE OF BIRTH (month, day, and year) Oct 1st 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	84	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Richard Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md.

14 Informant Thos. C Corner

(Address) 20 Merrymount Rd

15 FILED MAY 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1919, to May 19, 1923, that I last saw her alive on May 18, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder with metastasis to Ischium and Pubis (duration) 4 yrs 1 mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. of Bladder

(Signed) W. Gibson Porter, M. D.

5/20, 1923 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 5-21 1923

20 UNDERTAKER Howard Jenkins Sons Co.

ADDRESS Mitchell & Richardson

CAUSE OF DEATH should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

163492 No. D75922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D75922

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 11 WARD)

2-FULL NAME Harry Bunting

(a) RESIDENCE No. 823 Hamilton Terr. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Townsend

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 MAY 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7. 1923. to May 18. 1923

that I last saw him alive on May 15. 1923.

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Uremia

Myocarditis Degenerative

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? was at Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Chas. W. Cunningham M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 5-21 1923

20 UNDERTAKER Newnam & Eastman — ADDRESS Mitchell & Orchard

mation should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Mks.

Burg & Howard
B.&O.R.R.

D75923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 D75923

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 11 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Bayard

(a) RESIDENCE NO. 701 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 26, 1865

7 AGE 58 Years 3 Months 28 Days | If LESS than 1 day, hrs. or mtn.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney at Law

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Richard B. Bayard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Ellen Gilmor Howard

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Miss Ellen H. Bayard

(Address) 701 St. Paul St.

15 Filed MAY 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to May 19, 1923, that I last saw him alive on May 19, 1923, and that death occurred, on the date stated above, at 4 1 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

about

(duration) 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B. Jarrett, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del — DATE OF BURIAL 5-21-1923

20 UNDERTAKER Hennegan Jenkins & Jones Co — ADDRESS Mt Calvert Howard

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—12-23-21—F.B.R.S.—400 lbs.

D75924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75924

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Carroll

(a) Residence No. 808 Deadenball St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem.

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unkn.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unkn

12-MAIDEN NAME OF MOTHER, Unkn.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). "

14- (Informant) Anna Coston

(Address) 808 Deadenball St

15- Filed MAY 20 1923 ROBERT A. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 17 1923

17- I HEREBY CERTIFY, That I attended deceased from May 5 1923 to May 17 1923

that I last saw her alive on May 17 1923

and that death occurred, on the date stated above, at 11.40 a m.

The CAUSE OF DEATH* was as follows:

Huntington's Chorea with aphasia

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuffee

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Lab.

(Signed) W. McDowell M. D

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL. May 21 1923

20-UNDERTAKER, John W. Loadman — ADDRESS 142 Uhler St

Medical Certificate of Death must be filled. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospt. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Lepp

(a) RESIDENCE NO. Marriottsville Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 9 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Story

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Marriottsville Md

PARENTS

10 NAME OF FATHER Arthur Lepp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Marriottsville Md

12 MAIDEN NAME OF MOTHER Annie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sister, Cathryn Lepp (Address) Marriottsville Md.

15 MAY 20 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20-23

17

I HEREBY CERTIFY, That I attended deceased from 5-18-23, 19..... to 5-20-23, 19....., that I last saw him alive on 5-20-23, 19....., and that death occurred, on the date stated above, at 8.25 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

Cardiac Dilatation

(duration) yrs. , mos 1 ds.

CONTRIBUTORY (Secondary) Chronic & Acute Nephritis.

(duration) yrs. mos. 9 ds.?

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Signs

(Signed) H.C. Adkinson, M. D.

, 19 (Address) Md Gen Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sykesville Md

DATE OF BURIAL May 22 1923

20 UNDERTAKER Jno. R. Reed

ADDRESS Sykesville

mation SHOULD be carefully supplied. ANSWERS should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec—12-23-21—P.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75926 ✓ D75926

100-00

CERTIFICATE OF DEATH.

Registered No.....

D75926

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Thomas

(a) Residence No. 1609 Edmondson Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1877

7-AGE.	If LESS than 1 day.
45 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Operator

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. James Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Anna Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md

14- (Informant) Municipal Hospital Record

(Address)

15- Filed MAY 20 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 14, 1923 to May 18, 1923

that I last saw h.. alive on May 18, 1923

and that death occurred, on the date stated above, at 6:55 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell M. D

5-12-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Dulaney Cemetery	May 21 1923
20-UNDERTAKER.	ADDRESS 1532
George J. Smith	Hollins-11

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1837-003 ✓

D75927

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August A. Harr

(Residence in Baltimore: No. 2423 Fleet St.; yrs. 34 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	single

6-DATE OF BIRTH. June 15/1888 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
34 yrs. 11 mos. 3 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Well-driller
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. August A. Harr

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Catherine Nagle

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Harr

(Address) 2423 Fleet St.

Filed MAY 20 1923 192.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 18/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by autotruck- Fractured skull &leg- shock-cerebral Hem.

(Inquest to be held May 21/23)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Pallen M. D. (Coroner)

5/19/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem	May 21 1923
20-UNDERTAKER.	ADDRESS
John Ullrich	2008 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Jun 1875

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75928

CERTIFICATE OF DEATH.

X 94 D75928

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Happy Hills Convalescent Home ST.; 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hensel Brady

(a) RESIDENCE. NO. Coven ST.; WARD W. Va,

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 14-1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Lee Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Stella Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Ruby Renard

(Address)

15 MAY 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from November, 1922, to May 18, 1923, that I last saw him alive on May 18, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

— (duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes — Johns Hopkins Hospital

What test confirmed diagnosis?

(Signed) Benjamin Tappan M. D.

5/20/1923 (Address) 1102 North Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Coven W Va	May 20 23
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Reg

N. B.—WHITE PAPER, WHITE INK. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Status Lymphaticus

Spec.—1-10-21—MAT—1500 Bks.

D75929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D75929

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 S. Charles St. ST., 23 WARD)

2-FULL NAME Emma T. Smith.

(a) RESIDENCE NO. 1425 S. Charles ST., 23 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a [redacted] married, [redacted]
(or) WIFE of Louis C. Smith.

6 DATE OF BIRTH (month, day, and year) Sept, B. 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Frederick Moehle.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Fraener.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Louis C. Smith.
(Address) 1425 S. Charles St.

15 FILED MAY 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17

I HEREBY CERTIFY, That I attended deceased from June, 1920, to May 19, 1923,
that I last saw her alive on May 18, 1923,
and that death occurred, on the date stated above, at 2/40 p m.
The CAUSE OF DEATH* was as follows:

Organic heart disease
(Contributory Carcinoma of breast)

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Carcinoma of breast
(duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs and symptoms

(Signed) A. Masterson M. D.
5/22 1923 (Address) 1733 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cemetery.	May, 22, 1923.

20 UNDERTAKER A. Howard Evans ADDRESS 1428 S. Charles St

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D75930 HEALTH DEPARTMENT—CITY OF BALTIMORE D75930

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE, (No. Homewood Hospital St., 2400 N. Charles St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. William T. Harvey

(Residence in Baltimore: No. 809½ E. Fort Ave. St.; yrs. 38 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. Feb. 7, 1885.
(Month) (Day) (Year)

7-AGE. 38 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Painter.
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.
10-NAME OF FATHER. Zacharih Harvey.
11-BIRTHPLACE OF FATHER, (State or Country). Va.
12-MAIDEN NAME OF MOTHER, Margaret Collins.
13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Benjamin Harvey.
(Address) 1512 Boyle St.

15. FILED MAY 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Injuries from a fall
Accident

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
(Duration) .....yrs.....mos.....ds.

(Signed) [signature] M. D.
(Coroner.)
May 22 1923 (Address) 963 W. Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Cedar Hill Cemetery. May 21, 1923

20-UNDERTAKER. ADDRESS
A. Howard Evans 1428 S. Charles St.

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-20-21—E.B.R.R.—400 Blks.

D75931

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D75931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emma Magness

(a) Residence No. 501 N. Montford St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer). 069

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. William Heck

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-(Informant). Municipal Hospital

(Address).....

15-Filed MAY 21 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 19-23

17- I HEREBY CERTIFY, That I attended deceased from 5-17 1923 to 5-19 1923.

that I last saw h.er alive on 5-19 1923

and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. McPowell M. D

. 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel County	5-21-23
20-UNDERTAKER.	**ADDRESS**
Wm E. Miller	2334 Jefferson

Should be carefully answered. Exact statement of OCCUPATION is very important. See that it may be properly classified. Exact statements in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75932

CERTIFICATE OF DEATH.

101-001 D75932

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2120 Cliftwood Ave ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Wooden

(a) RESIDENCE NO. 2120 Cliftwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Fauth

6 DATE OF BIRTH (month, day, and year) June 13, 1898

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
24	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) P. W. & B. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Eugene L Wooden

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Belle Zeta Anders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Perryville Md.

14 Informant Mrs. Pauline Wooden (Address) 2120 Cliftwood Ave.

15 MAY 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14 1923 to May 19 1923.

that I last saw him alive on May 18 1923,

and that death occurred, on the date stated above, at 1201 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Ex haustion

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Albert C. Dieruff M. D.

5/20 1923 (Address) 2027 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 5/21 1923

20 UNDERTAKER C. D. Fanning & Son 1923

ADDRESS 86 E Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75933 3/ D75933

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Potomac ST., 25 WARD 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melville A. Fisher

(a) RESIDENCE NO. 605 Potomac ST., WARD Baltimore

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER James Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Kate Hackett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Jas. Fisher

(Address) 605 Potomac Ave.

15 MAY 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922 to May 17, 1923.

that I last saw h... alive on May 16, 1923,

and that death occurred, on the date stated above, at ...a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 15 ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) Wm. Kerr, M. D.

(Address) 1107 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL May 21 1923

20 UNDERTAKER E. D. Fanning

ADDRESS 1461 Battery av.

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

Kohlhafer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75934

CERTIFICATE OF DEATH.

65 D75934

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 E Fort Ave. ST., 24 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Kohlhafer Jr.

(a) RESIDENCE NO. 39 E Fort ave. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Jacob Kohlhafer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Augusta

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Augusta Kohlhafer
(Address) 1518 Bretton St

15 Filed MAY 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10 1923 to May 15 1923.
that I last saw him alive on May 18 1923.
and that death occurred, on the date stated above, at 10.8 PM
The CAUSE OF DEATH* was as follows:

Mitral insufficiency & stenosis
Nephritis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jas A O'Donnell M. D.

5/21/23 (Address) 1078 W Fay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL May 21 1923

20 UNDERTAKER E. J. Fanning & Son — ADDRESS 1460 Battery Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hodgkins Disease

Spec. 1-10-21-MAT-1500 Blks.

Maud Goode.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75935

CERTIFICATE OF DEATH.

139 D75935

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1409 McCulloh ST., 11 WARD)

2-FULL NAME Maud Goode

(a) RESIDENCE NO. 1409 McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Goode

6 DATE OF BIRTH (month, day, and year): Abt May 15 1887

7 AGE: Years 35 Months 3 Days 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Mrs. Stude

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant: John Goode (Address): 1409 McCulloh

15 Filed MAY 21 1923 ROBERT R. KRAETER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 17th, 1923, to May 18th, 1923, that last saw h alive on May 17th, 1923, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

1 Thrombosis of Aorta

2 Acute Dilatation of Heart

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary): Very long standing Fibroid

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Chew, M. D.

(Address) 624 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 5/21 1923

20 UNDERTAKER: Samuel Wensley

ADDRESS: W Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Thrombosis of Abdominal
Fibroid Tumor of Uterus
No other history

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75936

CERTIFICATE OF DEATH.

40

D75936

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 606 N Bond St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Elliot

(a) RESIDENCE No. 606 N Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years: 49 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housekeeping 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Frederick Wathin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Dimond

(Address) 606 N Bond st

15 MAY 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18-1923

17

I HEREBY CERTIFY, That I attended deceased from 4-15-23, to 5-18-23 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 5,130 m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Gen'l Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Cardozo, M. D.

, 19 (Address) 1524 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury

DATE OF BURIAL: May 21 1923

20 UNDERTAKER: John W Henderson

ADDRESS 1602 E monument

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcus Infection

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75937

CERTIFICATE OF DEATH.

5 ✓ D75937

1-PLACE OF DEATH 1616 E Federal St

CITY OF BALTIMORE: (No. 1616 E Federal St., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hattes

(a) RESIDENCE No. 1616 E Federal ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Julia E Hattes

6 DATE OF BIRTH (month, day, and year) Dec. 24 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer S. Bonsal & Sons

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Hattes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth K Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Julia E Hattes (wife)

(Address) 1616 E Federal St

15 MAY 21 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1922, to May 18, 1923, that I last saw him alive on May 18, 1923, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 5 mos. 11 ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine tests

(Signed) C C Macdonald, M. D.

(Address) 1540 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL May 21 1923

20 UNDERTAKER Burkert & Burkert, Burkert & Burkert — ADDRESS 1739 Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75938

CERTIFICATE OF DEATH.

D75938

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Madison Ave St. 11 WARD)

2-FULL NAME Charles E. Fehler

(a) RESIDENCE NO. 902 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Fehler Divorced

6 DATE OF BIRTH (month, day, and year) June 3, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watch Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 634

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter Fehler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Virginia Bode

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: John F. Fehler

(Address) 902 Madison Ave

MAY 21 1923, 19 Filed

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to May 19, 1923, that I last saw him alive on May 18, 1923, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Liver.

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of July 1922

Was there an autopsy? No

What test confirmed diagnosis? Gastro-Enterology 1922

(Signed) Jolee S. Bishop, M. D.

(Address) 730 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: May 22, 1923

20 UNDERTAKER: Mrs. Mrs John F. Penfold & Son

ADDRESS: 801 W. Fayette

matter should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75939

CERTIFICATE OF DEATH.

90 D75939

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 166 W. Hughes ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Jackson

(a) RESIDENCE No. 116 W. Hughes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbiana, Alla.

PARENTS

10 NAME OF FATHER ????

11 BIRTHPLACE OF FATHER (city or town) (State or country) ???

12 MAIDEN NAME OF MOTHER Luyra Nelson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alla

14 Informant William Jackson

(Address) [illegible]

15 MAY 21 1923 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1923, to May 19, 1923, that I last saw her alive on May 19, 1923, and that death occurred, on the date stated above, at 10.00P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ONE ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Carroll, M. D.

May 21, 1923 (Address) 1400 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	May 23 1923
20 UNDERTAKER	ADDRESS
A. L. Brown & Son	638 N. Monty

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other History

Spec. 1-1921 M&T 1500 Blks.

D75940 HEALTH DEPARTMENT—CITY OF BALTIMORE D75940

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 W North Av ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charlotte E. DeLaney

(a) RESIDENCE NO. 1641 W North Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis DeLaney

6 DATE OF BIRTH (month, day, and year) July 12 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	75	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) New Market
(State or country) Md

PARENTS

10 NAME OF FATHER Hamilton Oliver

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Harriette Hammond

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Mr Ira Buckey
(Address) 1641 W North Av

15 MAY 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to May 19, 1923, that I last saw h.. alive on May 19, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Hemorrhage of Brain (Apoplexy)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Failing heart action

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) Ed Smith, M. D.

May 19, 1923 (Address) 1605 W North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Market Md — DATE OF BURIAL May 22 1923

20 UNDERTAKER Josiah Syfer — ADDRESS [redacted] Av.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D75941 HEALTH DEPARTMENT—CITY OF BALTIMORE D75941

CERTIFICATE OF DEATH. 179

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3116 Barclay ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene L Conner

(Residence in Baltimore: No. 3116 Barclay St.: 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown ....., 1856
(Month) (Day) (Year)

7-AGE, 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Harford County Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. C. Elliott

(Address) 1123 Cathedral

15-

Filed MAY 21 1923 HUBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16 1923, to May 19 1923, that I saw him alive on May 19 1923, and that death occurred, on the date stated above, at 3:10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Several
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) Edwin K. Ballard M. D.

May 21, 1923 (Address) 1622 Mt Royal Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cemetery — DATE OF BURIAL, May 17 1923

20-UNDERTAKER Mrs R. C. Elliott — ADDRESS 1123 Cathedral

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75942

CERTIFICATE OF DEATH.

129 D75942

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 Walbrook ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gottlob J. Hauser

(a) RESIDENCE NO. 1934 Walbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Anna C. Hauser

6 DATE OF BIRTH (month, day, and year) May 19, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 131

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Hauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna C Hauser (Address) 1934 Walbrook Ave

15 MAY 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1923, to May 19, 1923, that I last saw him alive on May 19, 1923, and that death occurred, on the date stated above, at 5-50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos 24 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 4 mos. 24 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Examination & Exam. Urine

(Signed) H W Billups, M. D.

MAY 19 1923 (Address) 222 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park — DATE OF BURIAL MAY 22 1923

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON Ave

Notice—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D75943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75943

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 N. 10th St.; 76 WARD)

REGISTERED No. C 161-00

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Premature Inf. Schadel

(Residence in Baltimore: No. 104 N 10th St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Infant

6-DATE OF BIRTH, May (Month) 20 (Day), 1923 (Year)

7-AGE, Premature Infant. If LESS than 1 day, ...hours. or 4 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). 104 N. 10th St

PARENTS.

10-NAME OF FATHER, Henry Schadel

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Anna Bock

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father (Henry Schadel)

(Address) 104 N. 10th St

15-

Filed MAY 21 1923 ROBERT R. KRAUTER, Clerk of Permits.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~Sept~~ May (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1923 to ...191..., that I saw him alive on May 20 1923, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Premature

4 hrs (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

...(Duration) ...yrs. ...mos. ...ds.

(Signed) D. T. Kelly M. D.

(Address) 1 May 20 1923 1 a.d. N. Linwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Schwartz

DATE OF BURIAL, May 21, 1923.

20-UNDERTAKER, Wm Cook

ADDRESS 502 E North

N. B.—Fill in all blanks in ink. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

Schadel

D75944 HEALTH DEPARTMENT—CITY OF BALTIMORE D75944

CERTIFICATE OF DEATH.

REGISTERED NO. C 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 N. 10th St., N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Premature Inf Schadel

(Residence in Baltimore: No. 102 N 10-th St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, May (Month) 22 (Day), 1923 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 4 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), 104 N. 10th St

PARENTS.

10-NAME OF FATHER, ~~Henry Bock~~ Henry Schadel

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Anna Bock

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father (Hen Schadel)

(Address) 104 N. 10th St

15- MAY 21 1923, 191... Filed ..... ROBERT N. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 22 1923 to ..... 191..., that I saw h[illegible] alive on May 22 1923, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) 4 hrs yrs. ..... mos. ..... ds.

(Signed) D H Keller M. D.

..... 191... (Address) 102 N. Linwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Schwartz — DATE OF BURIAL, May 24..., 1923

20-UNDERTAKER W M Cook — ADDRESS 502 E North Ave

N. B. Every question must be answered, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D75945 ~~D76358~~ HEALTH DEPARTMENT—CITY OF BALTIMORE D75945

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellsworth Norris

(a) RESIDENCE NO. 1833 N. Duncan ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Feb. 10 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Clarence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Lance

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) .....

15 MAY 21 1923 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1923, to May 20, 1923, that I last saw him alive on May 20th, 1923, and that death occurred, on the date stated above, at 1:20 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) ..... yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. A. McGee, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 22, 1923

20 UNDERTAKER Wm Cook Co — ADDRESS 502 E 60th

IMPORTANT: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75946 D75946

CERTIFICATE OF DEATH.

REGISTERED NO. C 12429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 E. Lanvale ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eli H. Brown

(Residence in Baltimore: No. 416 E. Lanvale St. St.; 45 yrs. about mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar 27, 1859 (Month) (Day) (Year)

7-AGE, 64 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Foreman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, Cornelius Brown

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Ludovey Brown

(Address) 416 East Lanvale St

15-

Filed....., 191.... Registrar.

Robert P. Garrison,

11923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 5 1920, to May 19 1923, that I saw h in alive on May 17 1923, and that death occurred, on the date stated above, at 1.40 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 4 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(Duration) yrs. 2 mos. ds.

(Signed) George C. Shannon M. D.

May 19, 1923 (Address) 720 Fulton ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge | DATE OF BURIAL, May 22, 1923.

20-UNDERTAKER Wm Levy & Son | ADDRESS 707 E Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75947

CERTIFICATE OF DEATH.

3/ D75947

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4 Armstrong Ave St. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Brayden

(a) RESIDENCE. No. 4 Armstrong St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3/1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas J Brayden

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma C Orlin

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Emma C Brayden

(Address) 4 Armstrong St.

15 May 21 1923 Robert P. Garrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1923

17 August 1916. (May 24-1923)

I HEREBY CERTIFY, That I attended deceased from October 1915 to May 20th 1923

that I last saw him alive on May 20th 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulm Tuberculosis.

6 yrs (duration) 8 yrs. 9 mos. ds. Autopsy

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) J. W. Kearon M. D.

1923 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 24 1923

20 UNDERTAKER Wm Crook ADDRESS 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

162853 D75948 / HEALTH DEPARTMENT—CITY OF BALTIMORE D75948

CERTIFICATE OF DEATH 100-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Lyle.

(a) RESIDENCE NO. 307 N. Anne St., ST., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		1	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Eloy Walker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Florence Lyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Robert P. Harrison, Registrar

MAY 21 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1923

17

I HEREBY CERTIFY, That I attended deceased from March 26. 1923, to May 15, 1923, that I last saw him alive on May 15, 1923, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia-Broncho

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS MAY 19 1923

Wm. E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Bks.

D75949

163270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75949

CERTIFICATE OF DEATH

5161-001

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., City

2-FULL NAME Baby White

(a) RESIDENCE NO. 631 Sterling (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) April 26, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) J. H. Hospital (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER Florence White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MAY 21 1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1923 to May 14, 1923 that I last saw h e alive on May 14, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

Hyperthophic Stenosis of Pylorus (duration) ... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) — (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis, M. D.

, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health — ADDRESS MAY 18 1923

Dep. Wm. F. Wiegand

JOHNS HOPKINS HOSPITAL

JOHNS HOPKINS HOSPITAL

JOHNS HOPKINS HOSPITAL

CAUSE OF DEATH is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state

Rpm—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75950 D75950

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 Woodbury Pl ST.: 13 WARD)

2-FULL NAME Baby Ruby

(a) RESIDENCE. NO. 2138 Woodbury Pl ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 1 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Talbot Ruby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sabra Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Talbot Ruby (Father)
(Address) 2138 Woodbury Pl
~~Robert E. Lee Baltimore Md~~

15 Filed . 19 Registrar

MAY 21 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19th May 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to May 19, 1923, that I last saw her alive on May 19, 1923 and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both Lungs
(Primary)
(duration) — yrs. — mos. — ds.

CONTRIBUTORY —
(Secondary)
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. F. Illegible, M. D.

May 19 23 (Address) 1127 Mercer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS
Commissioner Health.	MAY 21 1923

Wm. E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D75951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D75951

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 Woodbury Ave ST.: 13 WARD)

2-FULL NAME Baby Ruby

(a) RESIDENCE. No. 2138 Woodbury Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Talbot Ruby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Edith Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Talbot F. Ruby
(Address) 2138 Woodbury Ave

15 Filed MAY 21 1923 19 Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19th, 1923, to May 19, 1923, that I last saw h[illegible] alive on May 19, 1923, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth
(1 week)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. T. Friedrich, M. D.

5/19, 19 23 (Address) 1827 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health MAY 21 1923

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D75952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75952

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST., 18 WARD)

2-FULL NAME David Ennils

(a) RESIDENCE NO. 204 Amity st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER William Ennils

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Gaile

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Robert F. Garrison, ... 19 ..... Registrar

Burial Permit No. 34,617

MAY 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 17, 1923,

that I last saw him alive on May 17, 1923,

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ..... yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) H. Palaplacca, M. D.

5-18-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL ..... 19 ..

20 UNDERTAKER Commissioner Health.

ADDRESS MAY 21 1923

B—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN'S or state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-1921 M&T 1500 Bks.

D75953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75953

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2119 Lyndhurst Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma F. Lusby

(a) RESIDENCE NO. 2119 Lyndhurst Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? 71 yrs. 4 mos. 19 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 1, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Caleb Lusby

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Matilda Gosnell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary E. Eyeland
(Address) 2119 Lyndhurst Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk

21 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17

I HEREBY CERTIFY, That I attended deceased from ....., 19.18., to May 20 , 1923.

that I last saw her alive on May 19 , 1923,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Insufficiency

with Decompensation

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy - with Hemiplegia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole M. D.

5/24 1923 (Address) 2202 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 22 1923
20 UNDERTAKER	ADDRESS 1944
Harry W. Eblen	W. Nadhan

Form 13-23-21—E.B.M.S.—400 blks.

D75954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 14-001

City of BALTIMORE: (No. 825 George St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Alice Lee

(a) Residence No. 825 George St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 30-1873

7-AGE. 49 yrs. 6 mos. 19 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Jno Valentine

(Address) 825 George

13- Robert P. Harrison, 192 Registrar

MAY 21 1923 Burial Permit Blank.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 18, 1923

17. I HEREBY CERTIFY, That I attended deceased from May 15 1923 to May 18 1923

that I last saw h[illegible] alive on May 18 1923

and that death occurred, on the date stated above, at 2200 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Cooney M. D.

5-24 1923 (Address) 752 George

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Bm

DATE OF BURIAL, May 25 1923

20-UNDERTAKER Hewitt Bros Fun

ADDRESS 1400 Mosher

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75955 D75955

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Hospital, 6000 Belleville Ave. ST.: Catherine WARD)

2-FULL NAME 6 mo Foetus - Hughes

(a) RESIDENCE. No. ~~5314~~ 5300 Reedy Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 21-23

7 AGE	Years	Months	Days	If LESS than 1 day 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) 6000 Belleville Ave (State or country)

PARENTS

10 NAME OF FATHER Jos F Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Evelyn Smith

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

14 Informant Hosp. Records (Address)

15 Filed 19 Registrar

Robert P. Harrison
Burial Permit Clerk.

2 1 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21- 1923

17

I HEREBY CERTIFY, That I attended deceased from May-20, 1923, to May-21, 1923, that I last saw him alive on May 20, 1923, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

6 mo Foetus.

(duration) yrs. mos. 15 hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. C. Hoess. M. D.

4-24, 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Govan	5/22 1923
20 UNDERTAKER James Lipman Son	ADDRESS 1000 E. Pacca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... should be stated EXACTLY. PHYSICIAN'S ... state mation should be carefully supplied. AGE ... it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D75956 HEALTH DEPARTMENT—CITY OF BALTIMORE D75956

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1310 West Mulberry St., 14 Ward) Registered No. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Schwartz

(a) Residence No. 1310 West Mulberry St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Widow of Wm H. Schwartz

6-DATE OF BIRTH (month, day and year) July 26th 1858

7-AGE. 58 yrs. 9 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Frantz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Lilia Schwartz

(Address) 1310 W. Mulberry St

15- 1923 Robert F. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 19-1923

17- I HEREBY CERTIFY, That I attended deceased from April 14, 1923 to May 19, 1923 that I last saw h[illegible] alive on May 18, 1923 and that death occurred, on the date stated above, at 340 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pelvis cavity

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of St Agnes Hospital

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptom

(Signed) John A Crain M. D.

, 19 (Address) 101 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon cemetery

DATE OF BURIAL. 5/22/23 19....

20-UNDERTAKER. Geo. Robert & Son

ADDRESS 2503 Edmondson Ave

Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Y 2 instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D75957

D75957

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 N. Kenwood Ave. ST.) 7 (WARD)

2-FULL NAME William J. Reichill

(a) RESIDENCE No. 816 N. Kenwood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Reichill

6 DATE OF BIRTH (month, day, and year) April 4th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) $30

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Francis Reichill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Katie Reichill (Address) 816 N. Kenwood Ave

15 MAY 21 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923 to May 18, 1923

that I last saw h... alive on May 18, 1923

and that death occurred, on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Uremia Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

20 20, 19 (Address) 4500 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL May 22 1923

20 UNDERTAKER Geo. W. Frailey & Son ADDRESS 511 N. Wolfe

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN should state EXACTLY. AGE should be stated EXACTLY. PHYSICIAN'S should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION may be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be TION is very important. See instructions on back of certificates. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Nbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75958 D75958

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

2-FULL NAME John Barkley

(a) RESIDENCE No. Enfield N.C. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C. ?
(State or country)

PARENTS

10 NAME OF FATHER Barkley

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant: W. E. Barkley
(Address) Tillery N.C.

15 Robert F. Harrison, Registrar

MAY 21 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20 1923

17

I HEREBY CERTIFY, That I attended deceased from 2-16- 1921, to 5-20- 1923

that I last saw h[illegible] alive on 5-20- 1923,

and that death occurred, on the date stated above, at 8 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma — forehead, orbit, skin of neck, — recurrent.

(duration) — yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5/24/21 (Curet)

Was there an autopsy? no

What test confirmed diagnosis? Pathological Exam

(Signed) Karl Steinmuller, M. D.

May 20, 1923 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ENFIELD, N.C.

DATE OF BURIAL May 23 1923

20 UNDERTAKER ROBERT BROOKS & SON

ADDRESS CALHOUN & HOLLINS ST

B.—WRITE PLAINLY, WITH UNFADING INK. THIS INFORMATION should be stated EXACTLY. PHYSICIANS should be careful to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21–M&T–1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75959 D75959

CERTIFICATE OF DEATH.

46

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3061 Frederick Ave. WARD 70)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Gent

(a) RESIDENCE No. 3061 Frederick Ave ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Frederick Gent.

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1845

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
77	7	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. W. Krause

(Address) 3061 Frederick Ave

15 MAY 21 1923 Robert P. Garrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 20 '23

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1923, to May 20, 1923, that I last saw h[illegible] alive on May 17, 1923 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Munford R. Willis, M. D.

5-21 1923 (Address) 510 Hamburg St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. J. Oliver Cem — DATE OF BURIAL May 22 23 1923

20 UNDERTAKER: Easton Sons — ADDRESS Elliott City

B.—WHITE PAPER, should be stated EXACTLY. PHYSICIANS should be careful that AGE should be carefully supplied. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

D75960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75960

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Fremont ave ST. 17 WARD)

2-FULL NAME Sarah E. Donelson

(a) RESIDENCE No. 811 N. Fremont ave ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 0 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) ~~WIFE~~ of Geo F. Donelson

6 DATE OF BIRTH (month, day, and year) Dec. 20-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
	77	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md.

PARENTS

10 NAME OF FATHER Alexander Beall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fred Co. Md

12 MAIDEN NAME OF MOTHER Caroline Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fred. Co. Md.

14 Informant Ava Donelson
(Address) 811 N. Fremont ave

15 MAY 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 20, 1923,

that I last saw h.. alive on May 21, 1923,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage ruptured
Aortic Aneurism
Chronic Nephritis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Blandford M.D.

May 21 1923 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL May 23 1923

ADDRESS 1949 W. Northern

20 UNDERTAKER Harry W. Ehlen

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75961

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75961

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 747 W. Saratoga ST., 4 WARD)

2-FULL NAME. Santo Anello.

(a) RESIDENCE NO. 747 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept. 14/22

7 AGE: Years — Months 8 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Salatore Anello.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Josephine Liberto

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant (Address): Salatore Anello 747 W. Saratoga

15 Filed: May 21 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-20 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-18 1923, to 5-20, 1923

that I last saw h[illegible] alive on 5-19- 1923

and that death occurred, on the date stated above, at 6 A- m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical.

(Signed) S. Tendler M. D.

5-21 1923 (Address) 1604 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery

DATE OF BURIAL: May. 23 1923

20 UNDERTAKER: Geo. J. Rutt

ADDRESS: 1235 Hanford Ave

N.B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIAN should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. SIGNATURE AND ADDRESS of informant is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75962 ✓

D75962

71-001

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME Dorothy Roche

(a) RESIDENCE NO. 430 E. Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov 27-1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Roche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 ..... Registrar Robert F. Garrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1923, to May 20th, 1923, that I last saw h alive on May 20th, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Brain Abscess, Right Frontal

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Meningitis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of May 8

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) F. H. Reichert, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 5/23 1923

UNDERTAKER Chas. F. Vane & Son — ADDRESS 1186 Mt. Royal ave

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of mation should be properly classified. AGE so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75963

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D75963

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2300 Madison Ave ST., 13 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Waldorf

(a) RESIDENCE No. 2300 Madison Ave. ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Waldorf

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mannes Auld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Schopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Mannes Waldorf
(Address) 1808 Madison Ave.

15 Filed MAY 21 1923 Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20/1923

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1923, to May 20, 1923, that I last saw him alive on May 20, 1923, and that death occurred, on the date stated above, at 12:50 a.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of lungs from grip and high blood pressure

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) grip about 6 wks.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sputum exam. and physical exams

(Signed) J. F. Shemwell, M. D.

, 19 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL 5/22/1923.

20 UNDERTAKER David Sondheim ADDRESS 115-20 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

D75964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75964

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lyddeliam Hospital (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anda Ray.

(a) RESIDENCE NO. Runton, Md ST., WARD Runton, Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 22 - 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Runton Md

PARENTS

10 NAME OF FATHER Ed. Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Doris Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Esther Ray
(Address) Runton Md

15 Robert F. Harrison, Registrar

MAY 21 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1923, to May 21, 1923, that I last saw her alive on May 20, 1923, and that death occurred, on the date stated above, at 2:55 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal & tonsillar & pharyngeal

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No Culture (H)

What test confirmed diagnosis?

(Signed) Billingsley M. D.

5/21/23 (Address) Lyddeliam Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Waverly DATE OF BURIAL May 22, 1923

20 UNDERTAKER Wm. Lerch for E Norris ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75965

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 South Fremont St., W. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Hoecke

(a) RESIDENCE NO. 611 S. Fremont ST. 1st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frans. Hoecke

6 DATE OF BIRTH (month, day, and year) 6-19-1842

7 AGE: Years 80; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Joseph L. Merkel

(Address) 611 S. Fremont Ave

15 Filed ....., 19.... Robert F. Garrison, Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

21823

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17

I HEREBY CERTIFY, That I attended deceased from May 6 1923, to May 19 1923,

that I last saw her alive on May 19 1923,

and that death occurred, on the date stated above, at 1145 m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) M. B. Truemper M. D.

5/20 1923 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: May 21 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North

Spec.—1-10-21—M&T—1500 Blks.

D75966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75966

CERTIFICATE OF DEATH. X 39

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Theresa Levy

(a) RESIDENCE NO. Savannah, Georgia ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

8a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julius Levy

6 DATE OF BIRTH (month, day, and year): Nov. 21, 1870

7 AGE: Years 51 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charleston (State or country) South Carolina

PARENTS

10 NAME OF FATHER Daniel Haas

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Ernestine Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mr. Howard Schloss

(Address) Edmund & Pacca Sts.

MAY 21 1923 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1923, to May 21, 1923, that I last saw her alive on May 21, 1923, and that death occurred, on the date stated above, at 7:05 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

WW

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pernicious anemia & Tuberculosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Ant. Gastro-Enterostomy

Did an operation precede death? Yes Date of 4/19/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidor J. Fry, M. D.

(Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savannah, Ga. DATE OF BURIAL: 5/22/1923

20 UNDERTAKER: David Sondheim ADDRESS 117 20 W. Mt. Royal

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Abdominal

Spec.—1-10-21—M&T—1500 Blks.

163746 D75967

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D75967

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE; (No. 25 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Zamosky, Jr.

(a) RESIDENCE No. 33 Cedar St. ST., WARD Curtis Bay, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred never 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov. 3-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	1	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John E.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Emma Jelinek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 MAY 22 1923 ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to May 20, 1923, that I last saw h alive on May 20, 1923, and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - lobar

(duration) yrs. mos 3 5 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 5-17-23

Was there an autopsy? No

What test confirmed diagnosis? Thoracentesis

(Signed) A. A. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C. C.

DATE OF BURIAL May 22 1923

20 UNDERTAKER Frank Crockett

ADDRESS 1806 Eutaw

Spec. 1-10-21—MAT 1500 3bs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75968

CERTIFICATE OF DEATH.

129 D75968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Stricker ST., 16 WARD)

2-FULL NAME Matilda Heckman

(a) RESIDENCE NO. 1143 Stricker ST., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year):

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Asbury Heckman 1143 N Stricker

15 MAY 22 1923 RUDOLPH K. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/20 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/1 1923 to 5/20 1923, that I last saw h alive on 5/20 1923, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Chr. Nephritis

(duration) yrs. 4 mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce Litter, M. D.

5/21, 1923 (Address) 213 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: May 22 1923

20 UNDERTAKER: Wm. H. Cruse Son — ADDRESS: 1400 Maiden

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75969

CERTIFICATE OF DEATH.

31 D75969

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 N Stricker ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Bessie Turner

(a) RESIDENCE. No. 1028 N Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE Negro

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word) married

5a If married, widowed, or divorced (HUSBAND of / WIFE of) Harrison B Turner

6 DATE OF BIRTH (month, day, and year) June 10, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
26	25	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Elijah Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER ~~Emily Johnson~~ Lancie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Ella Garner (Address) 1028 N Stricker

15 Filed . 19 Robert N. Kranich, Registrar

MAY 22 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20- 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 . 1923, to 5-19 . 1923.

that I last saw h.. alive on 5-19- . 1923.

and that death occurred, on the date stated above, at 9 a m

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs and enteritis

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Philadelphia ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical diag

(Signed) Victor Richards M. D.

. 19 (Address) Fidelity Bldg -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co Farm

DATE OF BURIAL May 22 1923

20 UNDERTAKER Thomas E. Chilcoat

ADDRESS 1400 Mahon

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75970 + 129 D75970

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Christs Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rayfield

(a) RESIDENCE NO. Emancoke, Va.. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE: Years 66; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Emancoke Va

PARENTS

10 NAME OF FATHER: Zephiah Rayfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unk

14 Informant: Levi Rayfield

(Address): Emancoke Va

15 MAY 22 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 16 1923 to May 20 1923 that I last saw him alive on May 20 1923 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

Chronic Bright Disease

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease & Complications Disease duration yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Emancoke. Va.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr J W Kennard M. D.

5-20 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emancoke Va — DATE OF BURIAL: May 22 1923

20 UNDERTAKER: Sam W Case Sr — ADDRESS: 1400 Mosher

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75971 HEALTH DEPARTMENT—CITY OF BALTIMORE D75971

163620

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Carter

(a) RESIDENCE NO. St. Mary's Home, ST. Preston & Gilmor Sts., WARD City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 15th 1910

7 AGE: Years 12 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Scholar.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mariah Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed MAY 22 1923 ROBERT M. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1923, to May 20, 1923, that I last saw h/m alive on May 20, 1923, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: May 23 1923

20 UNDERTAKER: Harmon & Albaugh — ADDRESS: 1364 Mary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75972

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 940 S. Third St ST., No WARD)

2-FULL NAME George C. Baier

(a) RESIDENCE NO. 940 S. Third ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 17-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil works.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. (State or country) Md

PARENTS

10 NAME OF FATHER Paul Baier

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Emelia Becker.

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md

14 Informant Paul Baier (Address) 940 S. Third St.

15 MAY 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 11 1923. to May 21 1923.

that I last saw h[illegible] alive on May 21 1923.

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

2 yrs 6 mos

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Jones, M. D.

May 22, 1923 (Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL May 24 1923.

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 N Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75973

CERTIFICATE OF DEATH.

D75973

159-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4617 Eastern Ave ST. 36 WARD

2-FULL NAME. William Clinton Grammer

(a) RESIDENCE. No. 4617 Eastern Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) June 6 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Oliver C. Grammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spamsburg Md

14 Informant Helen Grammer

(Address) 4617 Eastern Ave

Filed MAY 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20 1923

17

I HEREBY CERTIFY, That I attended deceased from 5/12, 1923, to 5/20, 1923, that I last saw him alive on 5/20, 1923 and that death occurred, on the date stated above, at 8 20 P.M.

The CAUSE OF DEATH* was as follows:

1 Broncho - Pneumonia

(duration) 7 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture Femur oral 8

Abscess Acute Glaucoma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Grammer, M. D.

5/21, 1923 (Address) 4617 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cath Lawn Cem.	May 22 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 N. Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D75974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-002 D75974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 W. North Ave St. 15 WARD)

2-FULL NAME Emanuel Spielbock

(a) RESIDENCE NO. 1710 W. North Ave, WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena S Spielbock

6 DATE OF BIRTH (month, day, and year) Russia.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Savannah Ga.
(State or country)

PARENTS

10 NAME OF FATHER Leopold Spielbock

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Minna Stern

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Schein
(Address) 1710 W. North Ave.

15 MAY 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to May 20, 1923, that I last saw h[illegible] alive on May 20/23, 19..., and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart —
Cirrhosis of Liver —

(duration) 1 yrs. mos [illegible] ds. —

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W J Gerry, M. D.

(Address) 622 Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cemetery	May 23 1923
20 UNDERTAKER	**ADDRESS**
J. Ahrens & Co	501 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Alcoholic

Spec.—1-10-21—MAT—1500 Blks.

D75975

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. Henning / 1923 / 11 / 31 / F5A / D75975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 S. Burtyloi ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Radtke

(a) RESIDENCE NO. 205 S Bentalow ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. / mos. / ds. How long in U. S., if of foreign birth? 50 yrs. / mos. / ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Radtke

6 DATE OF BIRTH (month, day, and year): July 20 1851

7 AGE: Years 71 Months 10 Days / If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (City or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fred. Radtke

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Frank Radtke (Address) 205 S. Bentalow St.

15 MAY 22 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 30 — 1922 to May 20, 1923.

that I last saw h[e] alive on May 20, 1923,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) Wells Henning M. D.

5/22, 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 23 1923

UNDERTAKER: F O'Neill — ADDRESS: 2236 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75976 90 D75976

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hanwood Hospital St. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ann Sellers

(a) RESIDENCE No. 807 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jacob Sellers

6 DATE OF BIRTH (month, day, and year): Aug 1846

7 AGE — Years: 76 — Months: 7 — Days: 10 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER: David H Glass

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Laura Blanck

(Address) 807 N Gilmor

15 MAY 22 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1923

17

I HEREBY CERTIFY, That I attended deceased from April 6, 1923 to May 20, 1923

that I last saw h alive on May 20, 1923,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Thrombosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 807 N Gilmor

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Lad Falkenhagen M.D.

19 (Address) 2724 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: 5/23/23

20 UNDERTAKER: W J Cushwa & Son — ADDRESS: Pa Ave & Dolphin Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75977

CERTIFICATE OF DEATH.

60-001 D75977

1-PLACE OF DEATH Church Home + Infirmary 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Mrs. Margaret Raabe

(a) RESIDENCE NO. 13 N. Milton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

*(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Raabe

6 DATE OF BIRTH (month, day, and year) June 24. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Sebastian Buerk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Rubin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Raabe (Address) 13 N. Milton Ave

15 Filed MAY 22 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to May 20, 1923, that I last saw h[illegible] alive on May 20, 1923, and that death occurred, on the date stated above, at 2 50 a m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

(duration) Not known. yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? Yes Date of May 19. 1923

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) Keith C. Rice, M. D.

, 19 (Address) Church Home + Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	May 23 1923
20 UNDERTAKER	ADDRESS
L. Sander Sons	1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75978

CERTIFICATE OF DEATH.

D75978

4 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 750 Vine ST.; 4 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Clarkson

(Residence in Baltimore: No. 750 Vine St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown (Month), 1 (Day), ... (Year)

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wesley Clarkson

(Address) 756 Vine St.

15- Filed MAY 22 1923 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 19 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1923, to May 19 1923, that I saw h Er alive on May 19 1923, and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

.....

Cardio-vascular Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. McEard M. D.

5/21, 1923 (Address) 2005 Hillan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Ct

DATE OF BURIAL, May 22, 1923.

20-UNDERTAKER J. L. Brown & Son

ADDRESS 108 W. Main

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D75979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75979

CERTIFICATE OF DEATH.

231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 838 S Sharp ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Bride

(a) RESIDENCE NO. 838 S Sharp ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sothie Bride

6 DATE OF BIRTH (month, day, and year) Jan 30 1594

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or estsblishment in which employed (or employer) Fertilizer Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Mack Bride

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Mulberry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant: (Address) Nettie Moore 838 S Sharp St.

15 MAY 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/1923

17 I HEREBY CERTIFY, That I attended deceased from 3/23/1923, to 5/21/1923, that I last saw him alive on 5/20/1923, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

Duration 2 mos.

CONTRIBUTORY (Secondary) Acute Bronchitis

Chronic (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no Clinical Microscop Exam

What test confirmed diagnosis?

(Signed) J. Wm. Bayley M. D.

5/21/1923 (Address) 1908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	May 24 1923
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	708 W. Mad.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spest.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75980

CERTIFICATE OF DEATH.

74-001

D75980

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Eutaw St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin L. Henry

(a) RESIDENCE. No. 702 Eutaw St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47 yrs.	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Expressman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Worchester Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Gaffard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Worchester Co. Md.

14 Informant (Address) Mrs. V. Henry Snyder 1913 Druid Hill Ave

15 Filed MAY 22 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19.. 1923

I HEREBY CERTIFY, That I attended deceased from 4/25.. 1923, to 5/19.. 1923, that I last saw h.. alive on 5/19.. 1923 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
Exposure

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam

(Signed) J. L. Shelton, M. D.

(Address) 703 N. Hamburg St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
E. Laurel Ct	May 22 1923
20 UNDERTAKER	ADDRESS
I. H. Brown & Son	101 W. Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Rupture of Brain — Not Luetic

Spec.—1-10-21—MAT—1500 Blks.

D75981
1331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D75981

REGISTERED NO.

1 PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Robertson

(a) RESIDENCE NO. 228 W. Biddle ST., ... WARD City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel S. Robertson

6 DATE OF BIRTH (month, day, and year) March 4, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 MAY 22 1923 HUBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923. to May 20, 1923.
that I last saw her alive on May 20, 1923.
and that death occurred, on the date stated above, at 9.05 P. m.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary embolus

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Cowles Andrus M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Cumberland	5-23-1923
20 UNDERTAKER George H. Holland	ADDRESS 163 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D75982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75982

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Warner St. ST., 21 WARD)

2-FULL NAME Ethel Beatrice Riley.C.

(a) RESIDENCE NO. 910 Warner St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. --- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ABBREVIATIONS SHOULD NOT BE USED. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Married.

5a If married, widowed, or divorced
(or) WIFE of Phillip Riley.C.

6 DATE OF BIRTH (month, day, and year) May 1st. 1897.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	26	0	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co. Md.

PARENTS

10 NAME OF FATHER James Weeks.C.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queen Anne Co. Md.

12 MAIDEN NAME OF MOTHER Manie Sanders.C.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Anne Co. Md.

14 Informant (Address) Arthur Weeks. + Queen Anne Co. Md.

15 MAY 22 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M Leinhardt, M. D. (Coroner.)

May 21st. 1923. (Address) 1217 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5/24 1923

20 UNDERTAKER Samuel T Kemp

ADDRESS 378 W Fayette

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75983

CERTIFICATE OF DEATH.

188-102 D75983

1-PLACE OF DEATH: Pronounced dead at

City of BALTIMORE: (No. St. Joseph Hospital St., 8 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Helen D. Reinig

(Residence in Baltimore: No. 2104 Mura St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	single

6-DATE OF BIRTH. Nov 23/1919 (Month) (Day) (Year)

7-AGE. 3 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Reinig

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER, Maggie Freitag

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).... Henry Reinig

(Address)..... 2104 Mura St.

15. FILED MAY 22 1923 ROBERT R. KRANTZ Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 20/23 (Month) (Day) (Year) 192...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over by a street car. Almost decapitated & head crushed.

(Inquest to be held May 21/23)

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) J. H. Collins M. D. (Coroner.)

5/21/23 192? (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer DATE OF BURIAL. May 23. 1923

20-UNDERTAKER. Peter Nicolaus ADDRESS 2060 Eastern Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

Removed to 2310 E. Federal St

D75984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D75984

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 N Broadway ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Lank Cohen (Cohen)

(a) RESIDENCE. NO. 125 N Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F Cohen

6 DATE OF BIRTH (month, day, and year): Oct 3, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	75	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Housework

9 BIRTHPLACE (city or town) (State or country): Concord Delaware

PARENTS

10 NAME OF FATHER: Robert Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Concord Delaware

12 MAIDEN NAME OF MOTHER: Elizabeth Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Concord Delaware

14 Informant: Mrs Anne L Moore
(Address): 125 N. Broadway

15 Filed MAY 22 1923 ROBERT M. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 19 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1922 to May 20, 1923, that I last saw h.. alive on May 19, 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. T. Howard, M. D.

May 19 23 (Address) 1201 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 23 1923

20 UNDERTAKER: John B. Spence ADDRESS: 1325 N. Carolina St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75985 31 D75985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 34 S Carlton St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Sauers

(a) Residence No. 34 S Carlton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND (or) WIFE of Marie Sauers

6-DATE OF BIRTH (month, day and year) Aug 9 1860

7-AGE. 63 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman Leather

(b) General nature of industry, business, or establishment in which employed (or employer) Retail

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Harford County Maryland

PARENTS

10-NAME OF FATHER. William H Sauers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-

(Informant) Carrie M Prelock

(Address) 47 W Woodland Ave

15-

Filed MAY 22 1923 19.. ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/20/23

17- I HEREBY CERTIFY, That I attended deceased from 5/5/23 19.. to 5/20/23 19.. that I last saw h.. alive on 5/19/23 19.. and that death occurred, on the date stated above, at 10:30 A. M. The CAUSE OF DEATH* was as follows:

Cachexia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulm Tb

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Will Bauer M. D

6/11, 1923 (Address) 502 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lorraine Cem	May 22 19 23
20-UNDERTAKER, George J Smith	ADDRESS 1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D75986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 411 N Carrollton Ave 18 129 Registered No.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ephraim F Provance

(a) Residence No. 411 N Carrollton St., ... Ward 18

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ellen J Provance

6-DATE OF BIRTH (month, day and year) May 12, 1840

7-AGE. 83 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) .....
(State or Country) Pennsylvania

PARENTS.

10-NAME OF FATHER, David Provance

11-BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Pennsylvania

12-MAIDEN NAME OF MOTHER, Rebecca Kelso

13-BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Pennsylvania

14- (Informant) Mrs L M Richardson

(Address) 411 N Carrollton Ave

15- Filed MAY 22 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 20-1923

17- I HEREBY CERTIFY, That I attended deceased from May 15 1923 to May 20 1923 that I last saw h[illegible] alive on May 20 1923 and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Ulc. Mesenteritis

(Duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

5 , 19 (Address) 3024 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL, May 23 19 23

20-UNDERTAKER, George J Smith — ADDRESS 153 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-001 D75987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel J. Corson

(a) RESIDENCE NO. 2040 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa Corson

6 DATE OF BIRTH (month, day, and year) Nov 6, 1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrical Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Alfred Corson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Amanda Lamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Teresa Corson

(Address) 2040 Edmondson Ave

15 Filed MAY 22 1923 ROBERT R. KRAUTER, Registr. Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20-1923

17

I HEREBY CERTIFY, That I attended deceased from 5-15-, 1923, to 5-20-, 1923, that I last saw h alive on 5-20-, 1923, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chron. Nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Thorough findings.

(Signed) Newton J. Brown, M. D.

5/22/, 1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 23 1923
20 UNDERTAKER George J. Smith	ADDRESS Hall

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D75988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D75988

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 S. Paca ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Weber

(a) RESIDENCE NO. 1017 S. Paca ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Weber

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mr. Thomas O'Neill. (Address) 1017 S. Paca St.

15 MAY 22 1923 ROBERT R. KRAUTER, Registrar [illegible] Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1922, to May 20, 1923.

that I last saw her alive on May 20, 1923;

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Paresis of the brain

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Dorsey, M. D.

5/24, 1923 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews cemetery

DATE OF BURIAL May 23 1923.

20 UNDERTAKER James Dignan & Son

ADDRESS 1000 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

(Approved by U. S. Census and American Public Health Asso.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lueti

Spec.—1-10 21—M&T—1500 Bks.

Mrs. Wissman.

D75989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7H-001 D75989

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 753 Washington Boulevard (St.) (Ward)

2-FULL NAME Catherine Sigwart

(a) RESIDENCE NO. 753 Washington Blvd. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Theodore Sigwart

6 DATE OF BIRTH (month, day, and year) Dec 14-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	75.	4		

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jacob Wissman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Mary Sigwart (Address) 753 Wash. Boulevard

15 Filed MAY 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12. 1923 to May 20. 1923

that I last saw her alive on May 19. 1923

and that death occurred, on the date stated above, at 5 45 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Primary Stroke 20 yrs ago

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

What test confirmed diagnosis? Clinical

(Signed) M C Spurrier M.D.

5/21/23 (Address) 682 West Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 5-23. 1923

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D75990 HEALTH DEPARTMENT—CITY OF BALTIMORE D75990

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Falls Road Nursing Home Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E Peddicord Jr.

(Residence in Baltimore: No. 1425 W. 25th St. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, ~~Divorced~~ (Write the word.)

6-DATE OF BIRTH. April (Month) 1 (Day) 1913 (Year)

7-AGE, 10 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer)..... Boy

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Thomas C Peddicord

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Bessie Gordon

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas C Peddicord
(Address) 1425 W 25th St

15. Filed ..... 192.. ROBERT N. KRAUTER, Registrar. Burial Permit Clerk. MAY 22 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:
Accidental
Drowning
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) John W. Russell M. D. (Coroner.)
May 21 1923 (Address) 832 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St Marys Hampden DATE OF BURIAL, May 23 1923

20-UNDERTAKER. Chenoweth Son Chestnut St

Spec.—1-10-21—M&T—1500 Blks.

D75991

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D75991

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 W. Conway ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Thomas

(a) RESIDENCE NO. 2 W. Conway ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Thomas

6 DATE OF BIRTH (month, day, and year): Sept 12/1888

7 AGE: Years 35 1888 | Months | Days | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Williams Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert County

12 MAIDEN NAME OF MOTHER: Sidney Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert County

14 Informant: Annie Thomas (Address): 2 W. Conway St

15 MAY 22 1923 ROBERT A. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 19, 1923, that I last saw h alive on May 19, 1923, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows: Pneumonia 2 days

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr. T. Hunter M. D.

(Address) 712 S. Wash Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery | DATE OF BURIAL: May 22, 1923

20 UNDERTAKER: Chas Scott Hosier | ADDRESS: 426 W. Conway St

Stmt.—6-9-19—H. P. Co.—1000 Blks.

D75992 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D75992

CERTIFICATE OF DEATH. 31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 N. Fortaw ST. 23 WARD)

2-FULL NAME. Lucy Adeline Marshall

(a) RESIDENCE. NO. 10 W Fortaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

3a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Millard Marshall

6 DATE OF BIRTH (month, day, and year) Sept 15 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

10 NAME OF FATHER Wm M. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Md~~ Penn.

12 MAIDEN NAME OF MOTHER Annie Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Glyndon Md

14 Informant Mrs A. Fisher
(Address) ~~1023 N. Fremont~~

15 Filed MAY 22 1923 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922 to May 20, 1923.
that I last saw her alive on May 20, 1923.
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy

(Signed) Wm L Steffey, M. D.

5/21, 1923 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	5/22/1923
20 UNDERTAKER Margaret E. Lyons	ADDRESS 1111 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form—12-23-21—E.B.P.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75993

CERTIFICATE OF DEATH.

D75993

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Graham B. Royster

(a) Residence No. Virginia St., Ward.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Graham Royster

6-DATE OF BIRTH (month, day and year) June 27 1855

7-AGE. 67 yrs. 10 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), North Carolina

PARENTS

10-NAME OF FATHER, Marcus Royster

11-BIRTHPLACE OF FATHER (city or town) (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER, Fanny Webb

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), North Carolina

11- (Informant) Hospital Record

(Address)

MAY 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 21 1923

17- I HEREBY CERTIFY, That I attended deceased from April 23 to May 21 1923

that I last saw h[illegible] alive on May 21 1923

and that death occurred, on the date stated above, at 9.10 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure (acute)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) H. J. Swadner M. D.

, 19 (Address) 1 W. Mulberry St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Carlsbrook Va	May 23 1923
20-UNDERTAKER.	ADDRESS
Geo. C. Stanley	Sutton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75994 ✓ D75994

CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) St. Joseph Hosp. ST., W WARD)

2-FULL NAME Baby Nichols

(a) RESIDENCE No. 45 N Whitridge Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22, 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Bernard Nichol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna McGowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Bernard Nichol

(Address) 45 N Whitridge ave

15 Filed MAY 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 19 23

17

I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to May 22, 1923,

that I last saw him alive on May 22, 1923,

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

asphyxia Neonatorum

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Marino, M. D.

May 23, 1923. (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL May 22 1923

20 UNDERTAKER L. A. Weidefeld Jr — ADDRESS 501 E 22 St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75995

CERTIFICATE OF DEATH.

159-002 D75995

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Riverside Ave. ST. 22 WARD)

2-FULL NAME Clinton D. Irwin Jr.

(a) RESIDENCE NO. 1027 Riverside Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state NAME should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. CAUSE OF DEATH is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 19th. 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	----------		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Clinton D. Irwin Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Clinton D. Irwin Sr. (father)
(Address) 1027 Riverside Ave.

15 Filed MAY 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

May 21st. 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

20 UNDERTAKER Margaret D. Flynn

DATE OF BURIAL May 22 1923

ADDRESS 1422 Light St

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D75996 — 44 D75996

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 S. Third St. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Wholey

(a) RESIDENCE NO. 709 S. Third St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A.* Wholey

6 DATE OF BIRTH (month, day, and year) Mar. 21 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer on B & O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER W. W. Wholey

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Harry Langrehr (Address) 709 S. Third St.

15 MAY 22 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20 19 23

17

I HEREBY CERTIFY, That I attended deceased from 3/10/23, 19..., to 5/20, 1923, that I last saw h[illegible] alive on 5/20, 1923, and that death occurred, on the date stated above, at 11⁵⁰ P. m.

The CAUSE OF DEATH* was as follows:

Intra Carcinoma
Endocarditis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. H. Garrell M. D.

5/21, 1923 (Address) 633-5-32 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 5/23 1923

20 UNDERTAKER: D. Tew McCully — ADDRESS: [illegible]

MARGIN RESERVED FOR REGISTRAR'S RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75997

CERTIFICATE OF DEATH.

74-001 D75997

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 324 S. Calhoun St ST. 21 WARD)

2-FULL NAME Samuel Chaney

(a) RESIDENCE NO. I323 Scott St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Halen E. Chaney (nee Jones)

6 DATE OF BIRTH (month, day, and year) August 11, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Unemployed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Williamsport Md.

PARENTS

10 NAME OF FATHER Louis Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Helen E. Chaney

(Address) I323 Scott St

15 Filed MAY 22 1923

ROBERT R. KNAUER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20- 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10- , 1923, to May 20- , 1923.

that I last saw h alive on May 19- , 1923,

and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds,

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lupton Dean, M. D.

, 19 (Address) 1127 Mosher Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 23 1923
20 UNDERTAKER	ADDRESS
Harry W. Fitzpatrick	1531 Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on lack of certificates.

MARGIN RESERVED FOR BINDING

D75998 HEALTH DEPARTMENT—CITY OF BALTIMORE V

D75998

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 Morton St., 12 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carroll Thomas

(Residence in Baltimore: No. 1712 Morton St.; yrs.,.....mos.....ds.)

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: April 1 (Month) (Day) 1923 (Year)

7-AGE: Yrs. Months Days: Infant — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Edwyd. Thomas

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Mary Berry

13-BIRTHPLACE OF MOTHER, (State or Country): Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Thomas

(Address) 1712 Morton

15- MAY 22 1923

ROBERT N. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20-23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Peritonitis

about 2 or 3 days

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) [illegible] M. D. (Coroner.)

May 17 192 3 (Address) 1634 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Laurel cemetery DATE OF BURIAL: May 22 1923

20-UNDERTAKER: Edward B. Forrest ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

Gracey.

D75999

HEALTH DEPARTMENT—CITY OF BALTIMORE

54

CERTIFICATE OF DEATH.

D75999

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Gracey.

(a) RESIDENCE NO. 504 N. Pulaski Park ave. ST., Baltimore. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gracey.

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Farrell

11 BIRTHPLACE OF FATHER (city or town) Balto - Md. (State or country)

12 MAIDEN NAME OF MOTHER Katherine Hand

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Johns Hopkins Hospital (Address) Per Keister

15 Filed MAY 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to May 21, 1923, that I last saw h alive on May 20 at 9 P.M., 1923, and that death occurred, on the date stated above, at 4.05 P.M.

The CAUSE OF DEATH* was as follows:

Pellagra; subsequent Anemia, diarrhoea; cachexia.

Feb 1922 - May 21, 1923 (duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Edema, Emphysema, Infection, Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Lyle A Allen, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 5/24/1923

20 UNDERTAKER Philip Hennig — ADDRESS 2016 Orleans

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76000 — 49 — D76000

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 145 N Linwood Ave ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Freitag

(a) RESIDENCE NO. 145 N. Linwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Annie Freitag

6 DATE OF BIRTH (month, day, and year) April 23 1867

7 AGE — Years: 55 — Months: 7 — Days: 26 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clothing

(b) General nature of industry, business, or establishment in which employed (or employer): Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Wm Freitag

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Annie Freitag

(Address): 145 N. Linwood

15 MAY 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1923, to May 19, 1923

that I last saw him alive on May 19, 1923

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Carcinoma of larynx

(duration) ....yrs. 8 mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) D. V. Kelly, M. D.

, 19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 5/23 1923

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D76001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST., 22 WARD)

2-FULL NAME Minnie De Blassi

(a) RESIDENCE NO. 119 E. Hughes st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Jos. De Blassi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Jemy Chiaramonte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Records

(Address) M. T. H.

15 Filed MAY 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 21, 19 23, to May 22, 1923,

that I last saw her alive on May 22, 1923,

and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Delagliacea, M. D.

5-22-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Bad

DATE OF BURIAL 5/25 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

D76002

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D76002

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 13 ST., WARD)

2-FULL NAME Dr. Ephraim Stone

(a) RESIDENCE NO. 3509 Reisterstown Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Nettie

6 DATE OF BIRTH (month, day, and year) Apr. 1-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Burroughs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 MAY 22 1923, Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14th, 1923, to May 20th, 1923, that I last saw h alive on May 20th, 1923, and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Uremia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Natalbany

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical tests

(Signed) Chas. W. Townsend M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrem Friendship Cem DATE OF BURIAL May 23 1923

20 UNDERTAKER Jack Levin ADDRESS 1439 E Baltimore

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76003

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76003

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 325 East 24th St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Henry Richards

(a) Residence No. 325 East 24th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Henrietta Richards

6-DATE OF BIRTH (month, day and year) May 22nd, 1847

7-AGE. 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Unknown.

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown,

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14- (Informant). Mrs Ella Knutter

(Address) 325 E. 24th St.,

15- Robert P. Harrison, 19 Registrar.

MAY 22 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 22-1923

17- I HEREBY CERTIFY, That I attended deceased from April 2nd, 1923, to May 21, 1923, that I last saw him alive on May 21st, 1923 and that death occurred, on the date stated above, at 4.40 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cemetery

DATE OF BURIAL. May 24, 1923

20-UNDERTAKER. Jos. C. Foster

ADDRESS Baltimore Md.

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76004

D76004

CERTIFICATE OF DEATH.

51

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Mangold ST., 21 WARD)

2-FULL NAME Rudolph W Huthmann

(a) RESIDENCE NO. 814 Mangold ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Meta L Huthmann

6 DATE OF BIRTH (month, day, and year) Sept 23 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or min.
62	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring at

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Huthmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Meta L Huthmann 814 Mangold St

15 Filed ..... 19..... Registrar

MAY 22 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1922, to May 21, 1923.

that I last saw him alive on May 20, 1923.

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(duration) yrs. 5 mos. 11 ds.

CONTRIBUTORY (Secondary) Pneumonia. (Hypostatic)

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Greenbaum, M. D.

5/22, 1923 (Address) 517 Loudon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 23 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76005

101-001

D76005

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore Md ST., 23 WARD)

2-FULL NAME Margaret M Cooper —

(a) RESIDENCE NO. 32 E. Barney ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant. Child.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 13 - 22

7 AGE: Years 1 Months and 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Russell Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Anna Reddish

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Consent Burial Records

(Address) Lombard & Eutaw Sts.

15 Filed ..... 19 .....

Registrar

MAY 22 1923 Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/21 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/17, 1923, to 5/21, 1923.

that I last saw her alive on 5/21, 1923,

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral lobar pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Empyema (right)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/17/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Lloyd Johnson, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: 5/22 1923

20 UNDERTAKER: Robt F Lahey & Sons ADDRESS 1318 Eutaw

1

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76006

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 W Cross ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Gonzalez

(a) RESIDENCE NO. 514 W Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Mar

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Cook Private Car

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cuba

PARENTS

10 NAME OF FATHER Frank Gonzalez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba

12 MAIDEN NAME OF MOTHER Joaquina Gonzalez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cuba

14 Informant Jos Gonzalez (Address) 614 W Belvedere St

15 Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

MAY 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to May 20, 1923, that I last saw h... alive on May 20, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Organic Dis. Heart

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

May 23, 1923 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 23 1923

20 UNDERTAKER Jos M. Juman

ADDRESS 1309 Druid Hill

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76007 ✓

D76007

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 Mosher ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Mrs Gabella Sessions

(Residence in Baltimore: No. 533 Mosher St.: ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby

6-DATE OF BIRTH, May (Month) 12 (Day), 1923 (Year)

7-AGE, ...yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Baby

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Gabella Sessions

11-BIRTHPLACE OF FATHER (State or Country) U. S.

12-MAIDEN NAME OF MOTHER Hazella Bird

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gabella Sessions

(Address) 533 Mosher St

15- Filed MAY 22 1923, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 21 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1923, to May 21 1923, that I saw h[illegible] alive on May 20 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature 7 months

Premature birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. L. Stevarte M. D.

5-21, 1923 (Address) 704 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, May 22, 1923

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1209 Druid Hill

MARGIN RESERVED FOR BINDING.

NOTICE.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D76008

D76008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

2-FULL NAME Amanda Sturgeon

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
67	0	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady.

(b) General nature of Industry, business, or establishment in which employed (or employer) Store -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bucks Md.

PARENTS

10 NAME OF FATHER Fred Sturgeon -

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Penna

12 MAIDEN NAME OF MOTHER Catt. Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Penna.

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Balto Md.

15 Filed MAY 22 1923 19 ROBT. P. GARRISON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1923

17

I HEREBY CERTIFY, That I attended deceased from May 11th, 1922, to May 22nd, 1923, that I last saw her alive on May 21st, 1923, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Paresis. (Senile)

(duration) 1 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Paralic Dementia -

(duration) 1 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 22, 1923 (Address) Mt Hope

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bells Cemetery Inc	May 24 1923
20 UNDERTAKER Clark & Turner	ADDRESS 17 & 2 N Bway

Burial Permit Given

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76009 ✓ D76009

CERTIFICATE OF DEATH.

164

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 926 N Wolfe ST., 7 WARD)

2-FULL NAME Mary Bell

(a) RESIDENCE NO. 926 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 93 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20th 1829

7 AGE: Years 93 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary Younger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Alice Bell (Address) 926 N Wolfe St

15 [illegible] 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to May 20, 1923.

that I last saw her alive on May 19, 1923.

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Constipation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr. M. D.

5/21, 1923 (Address) 2800 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetry — DATE OF BURIAL: May 23 1923

20 UNDERTAKER: Robt T Turner Inc — ADDRESS 1442 Broadway

MAY 22 1923

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76010

CERTIFICATE OF DEATH.

74-001 D76010

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 818 St. Peter St. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida E. Vanfosson

(a) RESIDENCE NO. 818 St. Peter St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Wm. Vanfosson

6 DATE OF BIRTH (month, day, and year) Dec. 15" 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Fosbender

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Pattner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. O. Vanfosson

(Address) 818 St. Peter St.

MAY 22 1923 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 20" 19 23

17 I HEREBY CERTIFY, That I attended deceased from May 10 . 19 23 . to May 20 . 19 23 . that I last saw h[illegible] alive on May 20 . 19 23 . and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bright's

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

5/21 19 23 (Address) 1227 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL May 23" 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bolton St

MARGIN RESERVED FOR BINDING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76011

CERTIFICATE OF DEATH.

REGISTERED NO. 114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2566 W. Baltimore St. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah R. Bollman

(a) RESIDENCE NO. 2566 W. Baltimore St. ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Bollman

6 DATE OF BIRTH (month, day and year) Oct. 15" 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob A. Freeburger

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah J. Brown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant George E. Bollman (Address) 620 Scott St.

15 MAY 22 1923 . 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21" 1923

17 I HEREBY CERTIFY, That I attended deceased from April 20 . 1923 . to May 21 . 1923 . that I last saw her alive on May 21 . 1923 . and that death occurred, on the date stated above, at 12.35 Noon

The CAUSE OF DEATH* was as follows:

Asthenia senilis, with Chronic Gastro-enteritis

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anuria

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) Robert W. Miffen, M. D.

5/21 1923 (Address) 1016 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL May 24 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Butts St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76012 ✓ D76012

CERTIFICATE OF DEATH

32

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home and Inf.

CITY OF BALTIMORE: (No. 176 N. Broadway ST., 2 WARD)

2-FULL NAME Mrs. Robert St. Rother

(a) RESIDENCE NO. 815 Columbia Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Opal E. Rother

6 DATE OF BIRTH (month, day, and year) Nov. 30th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Supt.

(b) General nature of industry, business, or establishment in which employed (or employer) Mt. Vernon Life Insurance Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Maurice Rother

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Daisey Longley

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs. Opal E. Rother

(Address) 1206 James St.

15 ..... 19 ..... Registrar Robert E. Harrison.

MAY 22 1923

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to May 21, 1923, that I last saw him alive on May 21, 1923 and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis - Simple - (Tuberculous)

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Examination Culture & Autopsy

(Signed) Richard G. Cottlentz, M. D.

5/22 1923 (Address) C. H. S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 24 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1603 N. Balto St

Spec.—6-9-19—H. P. Co.—1000 lbs.

D76013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Whombard St ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank F. Waldrick

(a) RESIDENCE. NO. 1721 Whombard St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~: married

5a If married, ~~widowed, or divorced~~ HUSBAND of (~~or WIFE of~~) Anna Waldrick

6 DATE OF BIRTH (month, day, and year) March 26, 1861

7 AGE: Years 62 | Months 1 | Days 24 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer): Postal

(c) Name of employer: U. S.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Waldrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothy Ochen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Howard Dykehouse

15 Filed ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19th, 1923, to May 30th, 1923, that I last saw him alive on May 30th, 1923, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH was as follows:

Acute Oedema of Lungs

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis & Decompensation (duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of

Was there an autopsy? no

What (test confirmed diagnosis?

(Signed) Howard Dykehouse, M. D.

May 22, 1923 Address 76 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 22 19 23

20 UNDERTAKER: John J. Fulda — ADDRESS 1200 W Lombard

MAY 22 1923

MARGIN RESERVED FOR BINDING

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76014

63155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76014

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. ST., 7 WARD)

CITY OF BALTIMORE: (No. .....

2-FULL NAME Mary Virginia Cale

(a) RESIDENCE NO. ..... Tyner, N. Carolina ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..yrs. few months ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of W. F. Cale

6 DATE OF BIRTH (month, day, and year) Dec 21-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Wife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Windsor
(State or country) N.C.

PARENTS

10 NAME OF FATHER Thomas Harrell
11 BIRTHPLACE OF FATHER (city or town) Windsor
(State or country) N.C.
12 MAIDEN NAME OF MOTHER Svarilla Mizell
13 BIRTHPLACE OF MOTHER (city or town) Windsor
(State or country) N.C.

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed Robert P. Harrison, Registrar

MAY 22 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1923, to May 21, 1923, that I last saw her alive on May 21, 1923, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Coronary embolus

one

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) auricular fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ..... Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Electrocardiogram

(Signed) E Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill N. C.

DATE OF BURIAL 5/22/23

20 UNDERTAKER H E Hughes ADDRESS 414 E. Broadway.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76015

CERTIFICATE OF DEATH.

11-001

D76015

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 E.25th ST., 12 WARD)

2-FULL NAME Clarence W. Callis

(a) RESIDENCE NO. 222 E 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ — HUSBAND of ~~WIFE of~~ Mary Melinda Callis

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Hay, Grain and feed

(c) Name of employer (Self) R.C.Wells & Co.

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James E.Callis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Mary Melinda Callis

(Address) 222 E 25th St.

15 Filed MAY 22 1923 Robert P. Harrison, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20. 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 20, 1923, that I last saw him alive on May 19, 1923, and that death occurred, on the date stated above, at 10:00 A. m.

The CAUSE OF DEATH* was as follows: —

La Grippe – Pneumonia

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W S Gray, M. D.

May 21, 1923 (Address) 699 W. Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	5-23-23 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76016

CERTIFICATE OF DEATH.

23 D76016

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 8 Idaho-ave.) ST., (Ward 29 WARD)

2-FULL NAME Margaret Amelia Cox.

(a) RESIDENCE NO. 8 Idaho-ave. ST., WARD

((Usual place of abode)) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 27th 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kaese La Grange Maryland

PARENTS

10 NAME OF FATHER George Herbert Cox

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Pillmeier

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

14 Informant George Herbert Cox (Address) 8 Idaho ave. Raspeburg

15 Robert F. Harrison Registrar

MAY 22 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to May 20, 1923, that I last saw her alive on May 20, 1923, and that death occurred, on the date stated above, at 4 o'clock a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pyelitis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert Webster, M. D.

May 21, 1923 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL May 23, 1923

20 UNDERTAKER Fred Lowman Sons — ADDRESS Fulberton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and undertaker's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAT—1500 Blks

D76017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76017

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1309 Myrtle Ave ST., 8 WARD)

2-FULL NAME Alfredo DeCosta

(a) RESIDENCE NO. 1309 Myrtle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary DeCosta

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica W. I.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary DeCosta

(Address) 1309 Myrtle ave

15 Filed MAY 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 — 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1923, to May 20 — 1923.

that I last saw living on May 19 — 1923.

and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis of Lungs 3 days

(duration) yrs. 7 mos 10 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(duration) yrs. 7 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. F. W. Kennard, M. D.

5-21, 1923 Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery

DATE OF BURIAL 5/23, 23

20 UNDERTAKER Earl J. Kennedy

ADDRESS 578 N. Eutaw St.

MARGIN RESERVED

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D76018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76018

CERTIFICATE OF DEATH.

74-00

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1669 Darley ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest C albert

(a) RESIDENCE. NO. 1669 Darley ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced, HUSBAND of ~~(or, WIFE of)~~ Elizobeth albert

6 DATE OF BIRTH (month, day, and year) September 14 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	72	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseshoer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ernest a albert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ernestine Mazabrud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Catherine Cartsonben 1669 Darley ave

15 Filed MY 23 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1 1922 to May 21 1923 that I last saw h.. alive on May 20 1923 and that death occurred, on the date stated above, at 4 45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. E. Bromback, M. D.

(Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	May 24th 1923
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

076019

CERTIFICATE OF DEATH.

90 D76019

Registered No. C.....

1-PLACE OF DEATH XXXXXXXXXXXXXX

y of BALTIMORE: (No. 1805 N. Broadway St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah W. Green

dence in Baltimore: No. 1805 N. Broadway St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	

OF BIRTH. Feb. 25/1853 1.....
(Month) (Day) (Year)

If LESS than 1 day,

yrs. 2 mos. 25 ds. ....hrs. or.....min.?

ATION:
Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Delaware

PARENTS

10-NAME OF FATHER. John Short

11-BIRTHPLACE OF FATHER. (State or Country). Delaware

12-MAIDEN NAME OF MOTHER. Amelia Atkinson

13-BIRTHPLACE OF MOTHER, (State or Country). New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Smullen

(Address) 1805 N. Broadway

15- MAY 23 1923 ROBERT K. KRAUTER,
Filed ..... 192 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 20/23, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac valvular insuffiency several yrs.- Chronic myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Culler M. D.
(Coroner.)

5/22/23 (Address) 508 E. North Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Olivet Cemetery DATE OF BURIAL, May 23 1923

20-UNDERTAKER, John A. Moran ADDRESS 3000 E. Baltimore St.

MARGIN RESERVED FOR BINDING

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76020

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76020

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 Townsend Place ST., 8 WARD)

2-FULL NAME Catherine Sullivan

(a) RESIDENCE NO. 1737 Townsend Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Widowed

5a If married, widowed, or divorced
~~Husband of~~ (or) WIFE of James Sullivan

6 DATE OF BIRTH (month, day, and year) January 15 1855

7 AGE: Years 68 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mary A. King
(Address) 1215 Saltzwood St.

BERT H. KRAUTER, Filed MAY 23 1923
Burial Permit Clerk. Registrar

MAY 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-18 1923 to 5-22 1923

that I last saw h[illegible] alive on 5-21 1923

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation.
Pronounced Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) [illegible] M. D.

5-22 1923 (Address) 800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents Cemetery — DATE OF BURIAL: May 24 1923

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Hanford Ave

Spec—12-23-21—E.B.F.S.—400 Blks.

D76021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Forest Ave. Hillsdale St., 28 Ward) Registered No. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice Ashby McLean

(a) Residence No. Forest Ave. Hillsdale St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. Lauchlin A. McLean

6-DATE OF BIRTH (month, day and year) June 3/1865

7-AGE. 57 yrs. 11 mos. 18 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore County

PARENTS.

10-NAME OF FATHER. Henry C Andrews

11-BIRTHPLACE OF FATHER (city or town) (State or Country). York Pa

12-MAIDEN NAME OF MOTHER. Alice A. Gott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Reisterstown Balto Co

11- (Informant). Ada M Andrews

(Address). 3305 Windsor Mill Road

MAY 23 1923

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 21 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 19 to May 21 19 23

that I last saw her alive on May 21 19 23

and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy)

(Duration) yrs. mos. 8 hours ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) A. C. Lauchlin M. D.

May 23, 1923 (Address) 4509 Gibury Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Windsor Park Cemetery	May 24 1923
20-UNDERTAKER.	**ADDRESS**
Harry H Annacost	4204 Edgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76022

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME Oscar C. Speese

(a) RESIDENCE NO. 314 Race ST., / WARD Sunbury Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or WIFE of)~~ Cora Speese

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Jacob Speese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sunbury Pa Unknown

14 Informant JOHNS HOPKINS HOSPITAL. (Address) .....

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 19 23

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to May 22 1923, that I last saw him alive on May 22, 1923, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma rectum

(duration) 1 yrs. X mos ..... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

postoperative (duration) ..... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 16 1923

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Emil Holman M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sunbury Pa	May 23 1923
20 UNDERTAKER	ADDRESS
Joseph Adrens	221 Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76023

CERTIFICATE OF DEATH.

101-001 ✓ D76023

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 N. Spring ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Plater

(Residence in Baltimore: No. 707 N Spring St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... unknown (Month) ..... (Day), 185[illegible] (Year)

7-AGE, 64 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jessie Plater

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catharine Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Mary F. Plater (wife)

(Address) ..... 707 N. Spring St.

15- MAY 23 1923 Filed ..... 191. ROBERT P. KRAUTH Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) ..... 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1923, to May 19 1923, that I saw him alive on May 19 1923, and that death occurred, on the date stated above, at 12 55 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... R J Young ..... M. D.

5/23, 1923 (Address) 1729 E Monument

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Asbury Cem. DATE OF BURIAL, May 24, 1923

20-UNDERTAKER Chas. H. Johnson 746 N. Carolina ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D7662 HEALTH DEPARTMENT—CITY OF BALTIMORE

D76024

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Poplar Ave. between Hickory Ave & Ash (ST.) (WARD)

2-FULL NAME Margaret Henry Lynch

(a) RESIDENCE NO. Poplar Ave. Govans ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, (or) WIFE of the Lat. Michael Lynch

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE: About 65 Years — Months — Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: James Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Ellen O'Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mrs. Geo. Rosendale

(Address) Poplar Ave. Govans

Filed MAY 23 1923 Burial Permit Issued Recorded

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1923, to May 20, 1923, that I last saw her alive on May 20, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Oedema of Lungs 4 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation of Heart 1 (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert G. W. Ebaugh M. D.

, 19 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 24 1923

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1201 E Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D76025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76025

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1984 N. Gay ST., 8 WARD)

2-FULL NAME Dietrich R. Schreifer

(a) RESIDENCE NO. 1984 N. Gay ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE~~ of Margaret A. Schreifer

6 DATE OF BIRTH (month, day, and year) Oct. 28 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor of

(b) General nature of industry, business, or establishment in which employed (or employer) Lunch Room

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Schreifer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mrs. Margaret A. Schreifer
(Address) 1984 N. Gay St.

15 Filed ..... 19 ROBERT E. KRAUTER Registrar
MAY 23 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to May 22, 1923, that I last saw h alive on May 22, 1923, and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular disease of Heart

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gehrig — M. D.

(Address) 6 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 25th 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—(THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D76026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76026

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 W Northern ST., 14 WARD)

2-FULL NAME Jacob Scher

(a) RESIDENCE NO. 831 N. Monticello ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) [redacted] of

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Scher

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Underman

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant (Address) Sister 831 W Northern

15 Filed MAY 23 1923 , 19 ROBERT E. HEATHER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23 1923

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1923, to May 22, 1923, that I last saw him alive on May 22, 1923, and that death occurred, on the date stated above, at 8-0 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage (Pulmonary) five minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Esophagus

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Exotin removed for Esophagus

(Signed) Charles Reit Eaton M. D.

5/23, 1923 (Address) 214 W Monument.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Belair Rd Cemetery

DATE OF BURIAL May 23 1923

20 UNDERTAKER Max Lennon

ADDRESS 1127 E Baltimore St

Apmc. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76027

CERTIFICATE OF DEATH.

31 D76027

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 273 S. Robinson ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winifred Turner

(a) RESIDENCE. No. 273 S. Robinson ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Turner

6 DATE OF BIRTH (month, day, and year) Apr. 20th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos. Murdock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Reilley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant Nicholas Turner.
(Address) 273 S Robinson

15 FILED MAY 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 25 1923, to May 21 1923, that I last saw her alive on May 20 1923, and that death occurred, on the date stated above, at 10 20 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Labor

(Signed) A. O. Tumbleson, M. D.

5/24, 1923 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 23 1923

20 UNDERTAKER	ADDRESS
John A Moran	3000 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76028

CERTIFICATE OF DEATH.

D76028

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 232 S. Washington St (WARD)

2-FULL NAME Mary E. Farrell

(a) RESIDENCE NO. 232 S. Washington WARD 2

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER John Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cassilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Mary E. Farrell (Address) 232 S. Washington

15 MAY 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1923, to May 21st, 1923,

that I last saw h[illegible] alive on May 21st, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Peritonitis (Ruptured Appendix) Refused operation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Hebb Judy, M. D.

5/22 1923 (Address) 330 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL 5/24 1923

20 UNDERTAKER J. G. Moran ADDRESS 320 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76029

CERTIFICATE OF DEATH.

74 901 D76029

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Josephs Hos. ST., 8 WARD)

2-FULL NAME Mrs Blanche O. Hargett.

(a) RESIDENCE NO. 1217 N. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche O. Hargett

6 DATE OF BIRTH (month, day, and year) 7 - 3 - 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	40.	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work supt United Rl'wy

(b) General nature of Indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md. (State or country)

PARENTS

10 NAME OF FATHER Levin D. Hargett

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Delashnutt

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. B. O. Hargett (Address) 1217 N. Milton Ave.

15 Filed ROBERT R. KRAUTER, MAY 23 1923 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923 to May 22, 1923.

that I last saw ... alive on May 22, 1923.

and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes. X

Did an operation precede death? Date of

Was there an autopsy? X

What test confirmed diagnosis?

(Signed) Jos. A. Schwaigh, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Md.

DATE OF BURIAL 5/25 1923

20 UNDERTAKER J. Fen McCully

ADDRESS 1305 E. Fort

MARGIN RESERVED FOR CONSECUTIVE NUMBERING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76030

D76030

REGISTERED NO. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 Covington St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria K. Bosley

(a) RESIDENCE NO. 1524 Covington St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James H. Bosley

6 DATE OF BIRTH (month, day, and year) 5 1 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	60	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Stonesyfer

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant James H. Bosley
(Address) 1524 Covington St.

15 Filed MAY 23 1923 ROBERT R. KRAETER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1923, to May 21, 1923, that I last saw her alive on May 21, 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis, hypertension

(duration) 1 yr. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) M. Lebkicher, M. D.

5/23 1923 (Address) 1019 Eighth St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 5/24 1923

20 UNDERTAKER J. F. McCully

ADDRESS 130 E Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

Spec.—1-10-21—M&T—1500 Blks.

D76031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86 D76031

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 White Ave Hamilton ST. 27 WARD)

2-FULL NAME Mamie Padgett

(a) RESIDENCE NO. 31 White Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Padgett

6 DATE OF BIRTH (month, day, and year): Aug 16-1883

7 AGE — Years: 39 — Months: 9 — Days: 6 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Albert Willert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Dora Lurz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Harry Padgett
(Address) 31 White Ave

15 Filed MAY 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1923, to May 21, 1923, that I last saw h alive on May 21, 1923 and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Malignant Endocarditis

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Temple Long, M. D.

5/22, 1923 (Address) 27 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: May 24, 1923

20 UNDERTAKER: John Ulrich — ADDRESS: 208 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76032

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 N. Collington Ave Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Maggie Dann

(a) Residence No. 414 N. Collington Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Dann

6-DATE OF BIRTH (month, day and year) Oct 1 - 1861

7-AGE, 61 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Yaeger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Don't know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant)..Louis Dann.....

(Address)....414 N. Collington Ave.....

15-

Filed..... 192.. ROBERT R. KRAUTER, Registrar.

MAY 23 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 22 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 31, 19 22, to May 22, 19 23

that I last saw h.. alive on May 21, 19 23,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Heck M. D.

May 24 1923 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL, May 25, 1923

20-UNDERTAKER, John Dellert — ADDRESS 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76033 161-00 D76033

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1030 N Calhoun ST., 16 WARD)

2-FULL NAME Baby Griffin

(a) RESIDENCE NO. 1030 N Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
F	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ~~7~~ hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Le Roy Waters

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Julia Griffin

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant
(Address)

15 Filed MAY 23 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-22-, 1923. to 5-22, 1923
that I last saw h.e alive on 5-22, 1923
and that death occurred, on the date stated above, at 2.45 p m.
The CAUSE OF DEATH* was as follows:
Prematurity.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Susanne R Parsons, M. D.

5-22 1923 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS MAY 23 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76034 101-001 D76034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D76034 Registered No. C.....

City of BALTIMORE: (No. 905 St. Barnabas Court St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John Scott

(Residence in Baltimore: No. 905 St. Barnabas Court St.; 30 yrs., ...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH. about ..... 1[illegible]
(Month) (Day) (Year)

7-AGE, 60 yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), Md.

PARENTS

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Scott

(Address) 905 St. Barnabas Court

15- Filed MAY 23 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

0403 THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(Duration).....yrs.....mos. 4D ds.

CONTRIBUTORY (Secondary) [illegible]

.....(Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.
(Coroner)

.....1923 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND. DATE OF BURIAL, ... 1923

20-UNDERTAKER, ADDRESS MAY 22 1923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D76035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76035

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME..... William Conway

(Residence in Baltimore: No. Lemmon St.; yrs. 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

6-DATE OF BIRTH. about 1868
(Month) (Day) (Year)

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Umbrella
(b) General nature of Industry, business, or establishment in which employed (or employer). Repairman

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N.K. Dep. Police Commissioner

(Address) Pennsylvania Ave

15-
Filed MAY 23 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an. Autopsy (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said. Autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wood alcohol poisoning

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) S. T. Hannigan M. D.
(Coroner.)

May 19 192 (Address) 210 Redwood St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 192

20-UNDERTAKER. ADDRESS

MAY 22 1923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0402

UNIVERSITY OF MARYLAND THE MORGUE

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76036 — 16-00D76036

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....(Boy) Smith.....

(Residence in Baltimore: No. 1521 E. Fayette.....St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	black	single

6-DATE OF BIRTH. May 9/23 (Month) (Day) 1..... (Year)

7-AGE. .....yrs.....mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Archer Smith

11-BIRTHPLACE OF FATHER. (State or Country). unknown

12-MAIDEN NAME OF MOTHER. Bertha unknown

13-BIRTHPLACE OF MOTHER. (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address).....

15- ROBERT P. KRAUSS

Filed MAY 23 1923 19 Burial Permit Issued by Registrar.

B5.98

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10/23 (Month) (Day) 19 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity (7 months gestation autopsy at hospital)

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Cullen M. D. (Coroner.)

5/19/23 19.... (Address 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. .....19....

JOHNS HOPKINS HOSPITAL

20-UNDERTAKER. ADDRESS

MAY 2 1923

Spec.—1-10-21—M&T—1500 Blks.

D76037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D76037

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital Lafayette & John ST. 2 6 WARD)

2-FULL NAME Baby Chapnek

(a) RESIDENCE NO. 16 N Monroe St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 20, 1923

7 AGE — Years — Months 1 day If LESS than 1 day ... hrs. or X min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Meyer Chapnek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rose Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hosp Records

(Address)

15 MAY 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1923, to May 21, 1923, that I last saw her alive on 11th am May 21, 1923, and that death occurred, on the date stated above, at 11.55 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) G. F. Goff M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL: May 23, 23

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Baltimore St

Spec.—8-24-14—M & T.—2000 Blks.

D76038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D76038

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 N. Durham St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie M. Brown

(Residence in Baltimore: No. 229 N. Durham St.; ....yrs., 8 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	single

6-DATE OF BIRTH, 6 (Month) 10 (Day) 1922 (Year)

7-AGE, ...yrs. 8 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Ernest Brown

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lila Chenoy

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Brown

(Address) 229 N. Durham

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23, 1913
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1913, to May 23 1913, that I saw h.. alive on May 26 1913, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 6 ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Cronin M. D.

May 24, 1913. (Address) 1925 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Albury Cemetery — DATE OF BURIAL, May 24, 1913

20-UNDERTAKER Miller Davis — ADDRESS 316 N Eden

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Y 231923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76039

CERTIFICATE OF DEATH.

100-001 D76039

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Colvin ST. 5 WARD)

2-FULL NAME Nicholas Defato (Di Fatta)

(a) RESIDENCE NO. 521 Colvin St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Defato Di Fatta

6 DATE OF BIRTH (month, day, and year) 6/12/187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Varnisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Defato Di Fatta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dora ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Di Fatta Italy

14 Informant (Address) Angela Defato Colv

15 MAY 23 1923 Robert P. Harrison, Registrar
19 .....
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 20th, 1923, to May 23, 1923, that I last saw h[illegible] alive on May 22, 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

B. Pneumonia

(duration) yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustavo A. Fiori, M. D.

5/23, 1923 (Address) Arcadia, Fla.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent Cemetery — DATE OF BURIAL May 25 1923

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76040 HEALTH DEPARTMENT—CITY OF BALTIMORE D76040

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 10 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Blackwell

(Residence in Baltimore: No. 727 Harford Ave St.; yrs. (mos. 3) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	black	single

6-DATE OF BIRTH. unknown ..... 1..... (Month) (Day) (Year)

7-AGE. 2 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). N. C.

PARENTS.

10-NAME OF FATHER. William Blackwell

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Carrie Christian

13-BIRTHPLACE OF MOTHER. (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address).....

15- Robert P. Harrison, 192 Registrar.

MAY 23 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Autopsy at Hospital)

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) S. A. Poe M. D. (Coroner.)

5/23/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence. North Carolina

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cem.	May 24 1923
20-UNDERTAKER.	ADDRESS
Wm. G. Locke	1302 Jefferson

13—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76041

CERTIFICATE OF DEATH.

161-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Druid Hill Ave ST. 14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) RESIDENCE NO. 1715 Druid Hill Ave ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Same~~

6 DATE OF BIRTH (month, day, and year) May 19, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ✓ hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Kemp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ky

12 MAIDEN NAME OF MOTHER Edna Brown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Edna Brown
(Address) 1715 Druid Hill Ave

15 Robert P. Harrison, M.D. Registrar

MY 23 1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19. 1923

17

I HEREBY CERTIFY, That I attended deceased from May 19th, 1923, to May 19th, 1923, that I last saw h alive on May 19th, 1923, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH was as follows:

Tremulous Foetus
6-7 months Gestation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. Lee Ellis, M. D.

5/22, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Laboratory — DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D76852
16282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76042

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME William Gray

(a) RESIDENCE NO. 1845 N. Chester St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 years How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J.

6 DATE OF BIRTH (month, day, and year) July 8-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER William J. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed ....., 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MAY 23 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1923, to May 22, 1923,

that I last saw him alive on May 22, 1923,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus -

(duration) 3 yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) multiple abscess -

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Shaw, M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 25, 1923

20 UNDERTAKER E. Le Roy Stifflen — ADDRESS 125 E Northlee

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76043

CERTIFICATE OF DEATH.

D76043

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Anchor ST.: 24 WARD)

2-FULL NAME Doris Evelyn Mynick

(a) RESIDENCE. NO. 1415 Anchor ST., WARD. 24

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5.23.23

7 AGE Years Months Days If LESS than 1 day, 10 hrs. or min.

6½ Fontal Month. Lived

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER W. Newton Mynick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Ruth Willard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lewis Del

14 Informant (Address) W Newton Mynick 1415 Anchor Pl

15 Filed MAY 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5.23 1923

17 I HEREBY CERTIFY, That I attended deceased from 5.23, 1923, to 5.23, 1923, that I last saw h[illegible] alive on 5.23, 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
Lived 10½ hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Feebleness (duration) yrs. 10½ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L J Burlington M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL May 24 1923

20 UNDERTAKER Lilly & Zulo

ADDRESS 403 S Wolfe St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRY should be made mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required by law to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76044

D76044

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 604 S. Eutaw ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Dogans

(a) RESIDENCE NO. 604 S. Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11th 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walter Dogans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Anne Tonney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant (Address) Irene Sorrell 604 S. Eutaw St.

15 Filed MAY 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19th, 1923, to May 23rd, 1923, that I last saw him alive on May 22nd, 1923, and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann.

(Signed) N. M. Robinson M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL May 24 1923

20 UNDERTAKER G. L. Brown & Son

ADDRESS 108 W. Monto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76045

CERTIFICATE OF DEATH.

22 202 D76045

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Rufus Daise

(Residence in Baltimore: No. 29 E. Church St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	black	single

6-DATE OF BIRTH. unknown (Month) (Day) 1..... (Year)

7-AGE. 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Am. Refining Co.

9-BIRTHPLACE, (State or Country). unknown

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER. "

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Southern Police Station

(Address).....

15- Filed MAY 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident- Fractured 7th cervical vertebra-injury to spinal cord. (Keg or kegs of manganese ore fell on him. Inquest to be held 5/24/23) (Duration)

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Oatis M. D. (Coroner.)

5/22/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	May 24 1923
20-UNDERTAKER,	ADDRESS
J. A. Bromwell Son	108 W. Monto

Spec. 6-9-19—H. P. Co.—1000 Blks.

D76046

HEALTH DEPARTMENT--CITY OF BALTIMORE

D76046

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 N. Calhoun ST.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Evans

(a) RESIDENCE. No. 1331 N. Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Smithville Calvert Co. Md.

PARENTS

10 NAME OF FATHER Richard Evans.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rachel Ann Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Smithville Calvert Co. Md.

14 Informant Zorah Hall (Address) 1331 N. Calhoun St.

15 Filed MAY 24 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to May 22, 1923, that I last saw h alive on May 20, 1923, and that death occurred, on the date stated above, at 6.10 A m.

The CAUSE OF DEATH* was as follows:

51

Carcinoma - Rt Breast.

Removed - (duration) 2 yrs., 2 mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical - Microscopical

(Signed) Milton N. Mays, M. D.

May 22, 1923 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn.	May 24 1923
20 UNDERTAKER Chas. N. Dennis	ADDRESS 1303 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76047 HEALTH DEPARTMENT—CITY OF BALTIMORE D76047

CERTIFICATE OF DEATH. 6 113

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ELLis Rubin

(Residence in Baltimore: No. 300 N. Ann St.; yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	

6-DATE OF BIRTH. Jan 8/23 (Month) (Day) (Year)

7-AGE. yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Abraham Rubin

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Ray Kirshter

13-BIRTHPLACE OF MOTHER, (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto st

Filed MAY 24 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilitation heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ileo Colitis

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J S K Raer M. D. (Coroner.)

5/24/23 192 (Address) 500 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Edmondson Avenue DATE OF BURIAL. May 24 1923

20-UNDERTAKER. Jack Lewis ADDRESS 1439 Bals

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76048

D76048

CERTIFICATE OF DEATH.

5N

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. 5 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abe Snyder

(a) RESIDENCE NO. 124 N. Front ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 1910

7 AGE — Years: 12 — Months: 5 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Aaron Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie Somerant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Levis 1439 E Balto St

15 Filed MAY 24 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1923, to May 23, 1923,

that I last saw h im alive on May 23, 1923,

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. 2 mos da.

CONTRIBUTORY (Secondary) Congestion of lungs, liver; anasarca

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Isidor I. Fry, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Cemetery — DATE OF BURIAL: May 24 1923

20 UNDERTAKER: Jack Levis, 1439 E Balto. — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—H.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76049

CERTIFICATE OF DEATH.

129 ✓ D76049

1-PLACE OF DEATH

City of BALTIMORE: (No.) 900 E. Biddle St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Huether

(a) Residence No. 900 E. Biddle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Christina Huether

6-DATE OF BIRTH (month, day and year) Feby 6 1851

7-AGE, 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Harry M. Huether

(Address) 803 E 33rd St.

15- Filed MAY 24 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 22 1923

17- I HEREBY CERTIFY, That I attended deceased from October 6, 1923, to May 22, 1923, that I last saw h[illegible] alive on May 22, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar F. Sauroc M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Mount — DATE OF BURIAL, May 25, 1923

20-UNDERTAKER: John O'Meteville — ADDRESS 1201 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 37 Harford Road (St.) Hamilton (WARD) 24

REGISTERED No. 90 K

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert H. Blackburn

(a) RESIDENCE No. 37 Harford Road (St.) Hamilton (WARD) 24

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cecelia E. Blackburn

6 DATE OF BIRTH (month, day, and year): May 17th 1854

7 AGE: Years 69 | Months — | Days 6 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Maryland

PARENTS

10 NAME OF FATHER: Jabez T. Blackburn

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Ann Walton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Earle H. Blackburn

(Address) 128 E. White St.

15 MAY 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1923

17

I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,

that I last saw h... alive on ..., 19...,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(duration) 2 yrs. 0 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

5/23 1923 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hiss Cemetery — DATE OF BURIAL: May 25 1923

20 UNDERTAKER: Frederick Lasaahn Son — ADDRESS: Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76051

CERTIFICATE OF DEATH.

145-002

REGISTERED NO. D76051

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 70 WARD)

2-FULL NAME Mrs. Mary Morris

(a) RESIDENCE NO. 2685 Delaney St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Morris

6 DATE OF BIRTH (month, day, and year) May 5 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Horan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Patrick Morris

(Address) 2685 Delaney St

15 MAY 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to May 22, 1923, that I last saw her alive on May 22, 1923 and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Occiput Posterior Presentation
High Forceps Delivery

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Surgical Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Moses Paulson, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL May 25 1923

UNDERTAKER John J Conway & Son Per J J Conway

ADDRESS 901 Hollins

Spec.—1-10-21—MAT—1500 Blks.

D76052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-002

D76052

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp. ST., 70 WARD)

2-FULL NAME Baby Morris

(a) RESIDENCE NO. 2665 Delaney St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2 hrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Agnes Hosp.
(State or country) Md.

PARENTS

10 NAME OF FATHER Patrick Morris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Horan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Mr. P. Morris
(Address) 2665 Delaney St

15 FILED MAY 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to May 22, 1923,
that I last saw him alive on May 22, 1923,
and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

1st Cerebral Trauma due to
high forceps delivery of occiput
posterior presentation 2 hrs.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) Moses Faulcon M. D.

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem	May. 1923
20 UNDERTAKER John J. Gaughan & Son.	ADDRESS
per G J Gaughan.	901 Walbrook

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spmc—6-9-19—H. P. Co.—1000 Blks.

D76053 HEALTH DEPARTMENT—CITY OF BALTIMORE D76053

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas O Rourke

(a) RESIDENCE. No Mt Hope Retreat ST., 28 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 72 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt 72		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Carpentering

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio -

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat

15 MAY 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1890 . 19 — to May 23 . 1923. that I last saw h[illegible] alive on May 23 . 1923. and that death occurred, on the date stated above, at 5.00 P. m. The CAUSE OF DEATH* was as follows:

Valvular Dis of Heart (Chronic)

for Years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Mania Post Acute Mania (duration) 35 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Columbus Ohio.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Cannery, M. D.

. 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cathedral Cemetery	May 24 1923
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODS, Successor)	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D76054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76054

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2935 Fait ave ST., 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice O. Kirby

(a) RESIDENCE NO. 2935 Fait Ave ST., 1st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Calet Kirby

6 DATE OF BIRTH (month, day, and year): Nov 28 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): John Kelly 1316 Bank St

15 Filed MAY 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1923, to May 21, 1923, that I last saw her alive on May 21, 1923, and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. L Long, M. D.

5-22, 1923 (Address) 201 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 25 1923

20 UNDERTAKER: H. Sander Son — ADDRESS: 1210 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76055

CERTIFICATE OF DEATH.

90 D76055

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3906½ Lloyd Ave ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Schaefer

(a) RESIDENCE No. 3906½ Lloyd Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sarah A. Schafer

6 DATE OF BIRTH (month, day, and year) Oct 10-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER John Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Markert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Joseph Schaefer (Address) 3906½ Lloyd St

15 Filed MAY 24 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17

I HEREBY CERTIFY, That I attended deceased from June 4, 1918, to May 22, 1923.

That I last saw him alive on May 22, 1923,

and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Chas L. Rahn, M. D.

May 23. 1923 (Address) 710 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ward Lane	May 25 1923

20 UNDERTAKER	ADDRESS
Wm Cook	3022 W. Fay

2135 Maryland

Spec.—1-10-21—M&T—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76056

CERTIFICATE OF DEATH.

179 D76056

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1136 Montpelier St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta E. Kloffenstein

(a) RESIDENCE NO. 1136 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Philip Kloffenstein

6 DATE OF BIRTH (month, day, and year) Nov 15 1840

7 AGE Years 82 Months 6 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian F. Velker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elmerick Shumacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry G. Klaffenstein

(Address) 1136 Montpelier

15 FILED MAY 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4 1923 to May 22 1923 that I last saw h[illegible] alive on May 22 1923 and that death occurred, on the date stated above, at 9.35 P m.

The CAUSE OF DEATH* was as follows:

Acute Chronic Interstitial nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank M Smith, M. D.

May 23 1923 (Address) 2430 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL May 25 1923

20 UNDERTAKER W. S. Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T Co., 1500 lbs.

D76057

Flora Gandy

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D76057

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 W. Lanvale ST., 16 WARD)

2-FULL NAME Mrs. Rose M. Gandy

(a) RESIDENCE NO. 1412 W. Lanvale St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred L. — yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose M. Gandy

6 DATE OF BIRTH (month, day, and year) Dec 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wilbert V. Hopper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sarah Kemp

14 Informant Rose M. Gandy
(Address) 1412 W. Lanvale

15 Filed MAY 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1920, to May 23, 1923, that I last saw her alive on April 15th, 1923, and that death occurred, on the date stated above, at 10:40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (Bilateral)

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) General Metastases yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Guy A. Cromwell, M. D.

May 23 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	26 1923

20 UNDERTAKER ..... ADDRESS

Wm Cook 502 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76058

CERTIFICATE OF DEATH. 74-001

D76058

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2927 Hinchester ST., 16 WARD)

2-FULL NAME Ida L. Koller

(a) RESIDENCE NO. 2927 Hinchester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Koller

6 DATE OF BIRTH (month, day, and year) Sept. 20 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jas H. Gallion

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachael A. Marsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John H. Koller

(Address) 2927 Hinchester St

15 MAY 24 1923 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to May 21, 1923,

that I last saw h[illegible] alive on May 20, 1923,

and that death occurred, on the date stated above, at 7-[illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. L. Fair M. D.

5/21, 1923 (Address) 2. E. 25.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park -	May 23 - 1923

20 UNDERTAKER Wm. Cook - ADDRESS 502 E. North Ave

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76059

D76059 CERTIFICATE OF DEATH. 182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Off Guarantine. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Wallis.

(a) RESIDENCE NO. 1803 N. Broadway. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 16th. 1905.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William H. Wallis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Lillie D. Bull.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant Lillie D. Wallis. (mother)
(Address) 1803 N. Broadway.

15 Filed MAY 24 1923 ROBERT N. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
Fall from a boat.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

May 24th, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Hill Md. DATE OF BURIAL: May. 24 1923

20 UNDERTAKER: W. E. Cook ADDRESS: 502 E. Fayette

N. B.—WHITE PENCIL, WITH CARBON PAPER, should be used in filling out this certificate. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76060

CERTIFICATE OF DEATH.

57 D76060

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 W. Balto ST., 19 WARD)

2-FULL NAME Sarah E. Frey

(a) RESIDENCE No. 1621 W Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Frey

6 DATE OF BIRTH (month, day, and year) Sept 22 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Page Co Va

PARENTS

10 NAME OF FATHER Erkine Bezel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Edenburg Va

12 MAIDEN NAME OF MOTHER Sarah Bayse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Page Co Va

14 Informant (Address) Mrs. 1621 W Baltimore

15 MAY 24 1923 ROBERT N. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5 , 1919 , to May 23 , 1923 , that I last saw h[illegible] alive on May 20 , 1923 , and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

7. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Kueneman M.D.

(Address) 1735 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Jackson Va	May 25 1923

20 UNDERTAKER	ADDRESS
Wm Cook	502 E Hoe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Clara Darr

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76061

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3109 Penna ave ST. 13 WARD)

2-FULL NAME Clara Darr

(a) RESIDENCE. No. 3109 Penna Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Darr

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Katz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Wemberg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Baum
(Address) 1619 N Fulton ave

15 MAY 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to May 23, 1923, that I last saw her alive on May 23, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis - Myocarditis

(duration) 1 yr. mes. ds.

CONTRIBUTORY (Secondary) Uraemic Convulsions

(duration) yrs. mos. 1 dy.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) H. C. Metzel M. D.

May 23 1923 (Address) 1903 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	May 25 1923
20 UNDERTAKER J. Ahrens & C	ADDRESS 1611 Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76062

162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) (Ward) 7

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Connelly.

(a) RESIDENCE No. 605 N Fremwood ave (St.) (Ward) .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Child

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS
10 NAME OF FATHER: Mark J Connelly
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md Unknown
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mark J Connelly
(Address) 605 N Fremwood ave

15 Filed MAY 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to May 23, 1923, that I last saw h[illegible] alive on May 23, 1923, and that death occurred, on the date stated above, at 3 P M

The CAUSE OF DEATH* was as follows:

1 Hemmorhage into adrenal glands

(duration) ... yr. ... mos. ... ds.

CONTRIBUTORY (Secondary) ✓
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) Myer Davidson M. D.
(Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state 1) Means and Nature of Injury, and 2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: May 24 1923

20 UNDERTAKER: John J Fields — ADDRESS: 1200 W Fayette and

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dystocia

Spec.—1-10-21—M&T—1500 Blks.

(See notebook)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76063

D76063

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Hudson ST., 1 WARD)

2-FULL NAME Stephen H. Graff

(a) RESIDENCE NO. 2408 Hudson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Theresa Graff

6 DATE OF BIRTH (month, day, and year) March 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipyard Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Yard 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Jacob Graff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Theresa Graff

(Address) 2408 Hudson

15 Filed MAY 24 1923 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1923 to May 22, 1923.

that I last saw him alive on May 21, 1923.

and that death occurred, on the date stated above, at 4 50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pettibone M. D.

, 19 (Address) 817 Hamilton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 5/25 1923

20 UNDERTAKER Philip Koerner — ADDRESS 2014 Orleans

REVISED UNITED STATES STANDARD

May 28-1923
To Health Department
City of Baltimore -
Dental Certificate of
Stephen L. Graff - Preston
8 - Precaution #4 caused -
major shock and
Dr. H. K. Peltekian
Surgeon

Rep. No. 1008

Phone Mt. Vernon 3264
DR. H. K. PELTEKIAN
817 HAMILTON TERRACE
BALTIMORE, MD.
Consultation Hours: 8 to 10 A.M. 1 to 2 P.M. 6 to 8 P.M.

Farmer (retired, 6 yrs.). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spec.—1-10-21 M&T 1500 Bks. Clyde L. Reger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76064

CERTIFICATE OF DEATH. X 129

D76064

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2nd & Gun Sts. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. C. Reger

(a) RESIDENCE No. Walkersville W Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Monroe L. Reger

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Walkersville
(State or country) W. Va

PARENTS

10 NAME OF FATHER Monroe L. Reger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) W. Va

12 MAIDEN NAME OF MOTHER Tesla Crawford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) W. Va

14 Informant Mrs C. N. Reger
(Address) 336 N. Chapel St

15 MAY 24 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23-23

17 I HEREBY CERTIFY, That I attended deceased from 5-16-23, 19..., to 5-23-23, 19...,
that I last saw him alive on 5-22-23, 19...,
and that death occurred, on the date stated above, at 4 45a m.
The CAUSE OF DEATH* was as follows:

Uremic Poisoning

(duration) yrs. mos 1 0 ds.

CONTRIBUTORY (Secondary) Chronic Dis. Myocardium

(duration) 4/5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Wiseman M. D.

, 19 (Address) 411 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arnold Md. DATE OF BURIAL May 23 1923

20 UNDERTAKER Harry W. Witzke ADDRESS 1521 Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D76065

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 Salem ST., 13 WARD)

2-FULL NAME Charles E Miller

(a) RESIDENCE NO. 2510 Salem ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1, 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Anna Feaney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant George Miller
(Address) 2510 Salem St.

15 MAY 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23. 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 21. 1923. to May 23. 1923.
that I last saw him alive on May 23. 1923.
and that death occurred, on the date stated above, at 3.45 P m.
The CAUSE OF DEATH* was as follows:

Bunchy Pneumonia

I was called May 21 and found the above ~~did not~~ known how long (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Whooping Cough
(duration) yrs. 1 mos. ds.

18 Where was disease contracted
If not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum examination

(Signed) Fred C Jewett, M. D.
May 23 1923 (Address) 2516 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 24 1923,
20 UNDERTAKER	ADDRESS
Martin Hickey Sons	827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Size—12-23-21—B.P.P.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76066

161-001

CERTIFICATE OF DEATH.

D76066

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 Cedarcroft St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas L. Galvin

(a) Residence No. 312 Cedarcroft St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 22/23

7-AGE. .....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or 20 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER John L. Galvin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mercedes Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Mercedes Galvin

(Address) 312 Cedarcroft St

15- MAY 24 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 22 1923

17- I HEREBY CERTIFY, That I attended deceased from May 22 1923 to May 22 1923

that I last saw him alive on May 22 1923

and that death occurred, on the date stated above, at 10:35 P. m.

The CAUSE OF DEATH* was as follows:

Dentition

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Premature birth

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Examination

(Signed) Thos. L. Galvin M. D.

, 19 (Address) 312 Cedarcroft St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cem	5/24/1923
20-UNDERTAKER.	ADDRESS
Chas E. Ernest & Son	1191 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE NAME OF DISEASE CAUSING DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

176067 31

REGISTERED NO. 10067

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 537 N. Biddle ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Hughes

(a) RESIDENCE No. 537 N. Biddle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (or) WIFE of Nelson Hughes

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Charles Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Sarah Hard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Melinda Holland

(Address) 587 Orchard St

15 MAY 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21. 1923

17 I HEREBY CERTIFY, That I attended deceased from March 30th, 1923, to May 21st, 1923, that I last saw her alive on May 21st, 1923, and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Miliary Tuberculosis

(duration) yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

5/22, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL May 24 1923

20 UNDERTAKER Mrs. R. C. Ellis ADDRESS 1 Eutaw Place

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76068

CERTIFICATE OF DEATH.

45 D76068

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 10 ST., WARD)

2-FULL NAME Louis F. McNulty

(a) RESIDENCE NO. 2010 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie C. McNulty

6 DATE OF BIRTH (month, day, and year) July 17 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	46	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Marie C. McNulty

(Address) 2010 W. Lexington St

15 Filed ....., 19.... ROBERT K. KRAUTER, Registrar

MAY 24 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to May 23, 1923, that I last saw him alive on May 23, 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Kidney (Small)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of May 21-1923

Was there an autopsy? No

What test confirmed diagnosis? Operation & Clinical

(Signed) Jane Hubert Wilkerson, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	May 25 1923
20 UNDERTAKER Bachelor & Son	ADDRESS 334 N. Howard St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76069

CERTIFICATE OF DEATH.

90 D76069

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2741 Harlem Ave ST. 16 WARD)

2-FULL NAME Agatha Kaufmann

(a) RESIDENCE NO. 2741 Harlem Ave ST., ... WARD .....
(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? 75 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: the late Urban Kaufmann

6 DATE OF BIRTH (month, day, and year): February 19 1837

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
86	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: M. Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. Agnes Freize

(Address) 2741 Harlem Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from April 10, 19 23 to May 23, 19 23, that I last saw her alive on May 23, 19 23, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): senile Dementia (Hrs)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy, M. D.

19 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May 26 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

24 1923

Spec.—1-10-21—M&T—1500 Blks.

D76070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76070

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1015 S. Paca. ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary. Ottey

(a) RESIDENCE NO. 1015 S. Paca. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Ottey.

6 DATE OF BIRTH (month, day, and year) Jan. 27-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Thomas McDonough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant: Husband Clarence Ottey

(Address) 1015 S Paca st.

15 Filed ..... 19 ..... Registrar

Robert P. Garrison,

Burial Permit Clerk.

MAY 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 22nd 23

17

I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to May 22, 1923

that I last saw h[illegible] alive on May 22 1923

and that death occurred, on the date stated above, at 4.35 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Dreier, M. D.

, 19 (Address) 109 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: May 25 1923,

20 UNDERTAKER: James Dignan & Son

ADDRESS: 1000 S. Paca

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76071 HEALTH DEPARTMENT—CITY OF BALTIMORE D76071

CERTIFICATE OF DEATH. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1322 Small ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Hawkens

(a) RESIDENCE NO. 1322 Small ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
44			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Marys Co Md (State or country)

PARENTS

10 NAME OF FATHER Allen Hunkens

11 BIRTHPLACE OF FATHER (city or town) St Marys Co Md (State or country)

12 MAIDEN NAME OF MOTHER Jane Coates

13 BIRTHPLACE OF MOTHER (city or town) St Marys Md (State or country)

14 Informant Mamie Green (Address) Washington D.C.

15 MAY 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1923, to May 22, 1923.

that I last saw him alive on May 18, 1923

and that death occurred, on the date stated above, at 230 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Acute) over

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Thomas Frey, M. D.

5/23, 1923 (Address) 1928 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenlawn Mem Park	May 25, 1923
20 UNDERTAKER	ADDRESS
Frank H. Case Sons	1400 Mosher

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Syphilitic

Spec. 1-10-21 MAT 1500 Blks.

D76072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D76072

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 4 WARD)

2-FULL NAME George W. Ellis

(a) RESIDENCE No. 777 W. Mulberry st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Frances Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records M.T.H. UNIVERSITY OF MARYLAND.

15 Filed ..... 19..... Registrar

Burial Permit Clerk.

MAY 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1923, to May 21, 1923, that I last saw him alive on May 21, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum,

(Signed) Francis L. Delagliacca, M. D.

5-21, 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: MAY 24 1923

20 UNDERTAKER: Commissioner Health

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 24 1923

Spec.—1-10-21—M&T—1500 Blks.

D76073

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76073

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph's Hosp. ST., OR WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sabina Rutkowska

(a) RESIDENCE NO. 933 Harris alley WARD 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Held

6 DATE OF BIRTH (month, day, and year) 1908-3-15

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	2,	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Rutkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Dakowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) John Rutkowski 933 Harris alley

15 Robert F. Harrison, . 19 Registrar

Burial Permit Clerk.

MAY 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1923

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1923, to May 22, 1923, that I last saw h alive on May 23, 1923, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bright's disease

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? C. S. & S.

(Signed) John J. Kriger M. D.

. 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May 25 1923
20 UNDERTAKER	ADDRESS
Stephen Frankowski	1001 Kenyon

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager" "Dealer," etc., without more precise specification, as *Day laborer—Farm laborer; Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76074

CERTIFICATE OF DEATH.

21 D76074

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1642 HAnover ST, ST., 23 WARD)

2-FULL NAME Rev. Francis M. Erdman.

(a) RESIDENCE NO. 1642 Hanover ST., 23. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna L. Erdman.

6 DATE OF BIRTH (month, day, and year) Dec. 21. 1894.

7 AGE — Years: 28. Months: 5. Days: 2. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Grace Reform Church.

9 BIRTHPLACE (city or town) (State or country): Shamokin Pa.

PARENTS

10 NAME OF FATHER: George Erdman.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Emma Adam.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): ANNA L. Erdman. 1642 Hanover St.

15 Filed MAY 24 1923, 19 Robert P. Garrison, Registrar

Burial Forest Glen.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23-1923

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to May 23, 1923, that I last saw him alive on May 23, 1923, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carbuncle of neck Erysipelas

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) M. L. Fichtenberg, M. D.

5/24, 1923 (Address) 22 W Madison Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shamokin. Pa. DATE OF BURIAL: May, 25. 1923.

20 UNDERTAKER: A. HOWARD EVANS. ADDRESS: 1428 S. Charles St.

B.—WRITE PLAINLY, WITH UNFADING INK—IN... mation should be carefully supplied. AGE sho... CAUSE OF DEATH in plain terms, so that it ma... it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on ba... on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76075

CERTIFICATE OF DEATH.

X92D76075

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes

CITY OF BALTIMORE: (No. Sta Agnes Hospital ST., 32 WARD)

2-FULL NAME Mrs. Madge Field.

(a) RESIDENCE NO. 29 E. 124 St. N. Y. ST., ... WARD New York N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Fields

6 DATE OF BIRTH (month, day, and year) May 22 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant Arthur Fields (Address) 29 E 124 St NY

15 MAY 24 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1923

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to May 24, 1923, that I last saw h e alive on May 24, 1923, and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

mesenteric Thrombosis of Caecum.
Gangrene of Caecum.
Peritonitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 23, 1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward H. Kotlowski, M. D.

, 19 ..... Address St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City	May 24 1923
20 UNDERTAKER Wm Cook	ADDRESS 32 E 125th

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D76076

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Berry / Broadway

89 D76076

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 104 East Lanvale ST. 12 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Frances Bond

(Residence in Baltimore: No. 104 East Lanvale St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH, ... Jan. (Month) 7th (Day), 1870 (Year)

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): St Marys Co Md

PARENTS.

10-NAME OF FATHER, Benedict Bond

11-BIRTHPLACE OF FATHER (State or Country): St Marys Co Md

12-MAIDEN NAME OF MOTHER: Mary F. Bond

13-BIRTHPLACE OF MOTHER (State or Country): St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Dimes Peake

(Address) Windsor Court Apartment

15- Registrar's Office Windsor Ter

MAY 24 1923 Robert P. Harrison, ..., 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) 23 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sudden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) W. P. Kelly M. D.

May 24 1923 (Address) 168 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, May 25 1923

20-UNDERTAKER Wm Cook Co

ADDRESS 502 E North Ave

NOTICE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

D76077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76077

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Westminister Hotel ST., Park + Fayette WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L McGee

(a) RESIDENCE No. Westminister Hotel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer) retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John McGee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Harry H. Miller

(Address) 1922 W[illegible]

Robert F. [illegible]

MAY 24 1923 , 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1923.

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to May 23rd, 1923.

that I last saw him alive on May 23, 1923;

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene (fingers)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of –

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams, M. D.

, 19 (Address) 2360 Eutaw place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Lawn

DATE OF BURIAL May 25 1923

20 UNDERTAKER Henry Hopkins Sons Co

ADDRESS McCulloh + Eutaw

B.—WRITE PLAINLY, WITH UNFADING INK—
mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b

D76078 HEALTH DEPARTMENT--CITY OF BALTIMORE D76078

CERTIFICATE OF DEATH

REGISTERED No. C 90

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 400 N. Fulton Ave ST. 20 WARD)

2 FULL NAME Mrs Jane E. Payne (See note on back.)

(Residence in Baltimore: No. Home for Aged of the M.E Church (10) St.; 72 yrs. mos. ds.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK

AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Aug (Month) 17, (Day) 1847 (Year)

7 AGE: 75 yrs. 9 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: Wm. Strothers

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Lettia Tolley

13 BIRTHPLACE OF MOTHER (State or country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta Cuddy

(Address) 400 N. Fulton ave.

15 Robert F. Harrison, Burial 191 Permit Clerk. REGISTRAR

JUN 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 23. (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to May 23 1923 that I saw her alive on May 23 1923. and that death occurred, on the date stated above, at 11-40 p.m.

The CAUSE OF DEATH* was as follows:

I was called at 11.15 and found her with Acute Cardiac Dilatation - She died at 11-40 p.m.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) See note on back

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), George E. Shannon M. D.

May 23, 1923. (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL: Mt. Olivet — DATE OF BURIAL: May 25 1923

20 UNDERTAKER: Geo. E. Smith — ADDRESS: 1532 N. Eu

and am issuing this certificate with his permission and sanction George C. Shannon MD

No other history

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus,*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—1-10-21—MAT—1000 Blks.

76079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76079

CERTIFICATE OF DEATH.

122-002 D76079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 33 N.Luzerne Ave. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Starr

(a) RESIDENCE NO. 33 N.Luzerne Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If ~~married, widowed, or divorced~~ (or) WIFE of James H.Starr

6 DATE OF BIRTH (month, day, and year) Dec.27.1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Abbott

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mrs Gertrude Lamar (Address) 33 N.Luzerne Ave

15 Robert F. Harrison, Registrar

MAY 24 1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21.1923

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1922, to May 21, 1923, that I last saw h~~er~~ alive on May 21, 1923, and that death occurred, on the date stated above, at 5:30P m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis..

Cardiac Lues

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Debility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. A. Thezin Jr. M. D.

5/24, 19 23 (Address) 2638 E. Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5-25-23
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-alcoholic

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76080 × 31 D76080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Boone

(a) RESIDENCE No. Rock Creek, A.A. Co., Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Washington Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed MAY 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1923, to May 24, 1923, that I last saw him alive on May 24, 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Multiple tuberculous ostoitis (duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 1921

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.

(Signed) Frances L. Balaylaeev, M. D.

5-24-23 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cemetery DATE OF BURIAL May 27 1923

20 UNDERTAKER Edward Bergman ADDRESS 1631 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16307
D76081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 D76081

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Helen Hall

(a) RESIDENCE No. 1604 Mulligan St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 17-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) N. J.

PARENTS

10 NAME OF FATHER Jesse Hall

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed MAY 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to May 23, 1923, that I last saw her alive on May 23, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) 0 yrs. 0 mos 28 ds.

CONTRIBUTORY (Secondary) Generalized tuberculosis

(duration) ..... yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes Post mortem examination

What test confirmed diagnosis? Tbc of peritoneum

(Signed) William H. F. Wartter, M. D.

, 19 (Address) Johns Hopkins Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 27 1923

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH ONE FADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76082

CERTIFICATE OF DEATH.

46 D76082

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2405 Arlans St., 6 Ward)

(If death occurred in a hospital or institution, give Its NAME instead of street and number.)

2-FULL NAME. annie A Huber

(a) Residence No. 2405 Arlans St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lewis Huber

6-DATE OF BIRTH (month, day and year) September 12 1854

7-AGE. 68 yrs. 8 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. John Lowrey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Alexandra

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-(Informant) Lewis Huber

(Address) 2405 Arlans St

15-MAY 25 1923 By: ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 23-23.

17- I HEREBY CERTIFY, That I attended deceased from May 3 1923 to May 23 1923, that I last saw her alive on May 23 1923 and that death occurred, on the date stated above, at 6. P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(Duration) Uncertain

CONTRIBUTORY (Secondary) General Carcinomatosis (Duration) Uncertain

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Examination of Scrapings

(Signed) W. Sugarman M. D

, 19 (Address) 434 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. May 26 19 23

20-UNDERTAKER. Wm F. Hartley

ADDRESS. 815 N. Eastern Ave

N. B.—WRITE PLAINLY. Words should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76083

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D76083

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N. Mount ST. 16 WARD)

2-FULL NAME Ernest Eder Dyson

(a) RESIDENCE NO. 722 N Mount ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 15, 1921

7 AGE — Years: 1 — Months: 7 — Days: 8 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): - did

(c) Name of employer: -

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Eugene Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary J. Ridgley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mary J. Dyson 722 N Mount St

15 MAY 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to May 23, 1923, that I last saw h[illegible] alive on May 22, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 2 yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary): Rickets

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) M. A. Druill M. D.

5/24, 1923 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 9/6 Year 19

20 UNDERTAKER: David Carton

ADDRESS: 5-25

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Only information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D76084

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 57 Gwynn ST. 17 WARD)

2-FULL NAME Agnes L. Brown

(a) RESIDENCE NO. 57 Gwynn ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Mar. 25 / 23

7 AGE: Years — Months 1 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Benny Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Grace Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address)

15 MAY 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to May 26, 1923, that I last saw h[illegible] alive on May 23, 1923 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Ac. Gastro-enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cephalosporin

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

, 19 (Address) 1706 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 5-26-1923

20 UNDERTAKER: [illegible]

ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76085

CERTIFICATE OF DEATH.

166-001

D76085

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Hillmen ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Heath

(a) RESIDENCE NO. 703 Hillmen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Sing G

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City.

PARENTS

10 NAME OF FATHER Lawrence Heath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Heath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Heath

(Address) 703 Hillmen St

15 Filed MAY 25 1923, 19.... ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to May 23, 1923, that I last saw h[illegible] alive on May 23, 1923, and that death occurred, on the date stated above, at 11:45 Pm.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R B Kenyon, M. D.

May 24, 1923 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 5-25-1923

20 UNDERTAKER David Easter

ADDRESS Ca

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-002
D76086

CERTIFICATE OF DEATH.

D76086

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospital ST., 2 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Karis

(a) RESIDENCE NO. 401 Sanders Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George A.

6 DATE OF BIRTH (month, day and year) Feb 28, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work HW 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS
10 NAME OF FATHER George Keppler
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Louise Koerl
13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant (Address) Geo A Karis 401 Sanders St

15 MAY 25 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-23

17 I HEREBY CERTIFY, That I attended deceased from 5-6-23, 19..., to 5-22-23,
that I last saw h alive on 5-22-23, 19...,
and that death occurred, on the date stated above, at 10:50 m.
The CAUSE OF DEATH* was as follows:

Cardiac failure
Uremia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-21-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Mysliwiec, M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 25 1923
20 UNDERTAKER	ADDRESS
F.A. Krause & Son	733 Hanover St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PENCIL MUST NOT be used.
Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

163567 D76087 + 84 D76087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. 1 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lewis Meyers

(a) RESIDENCE No. Walter Reed Hospital, ST. Washington, D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced (or) ~~WIFE~~ of: Mrs. Margaret Dillon Meister

6 DATE OF BIRTH (month, day, and year): Feb. 2, 1888.

7 AGE: Years 35 Months 2 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ex-Soldier

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New York.

PARENTS

10 NAME OF FATHER: Lewis W. Meyers.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Senft

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 ~~JOHNS HOPKINS HOSPITAL~~ Informant (Address): Records.

15 FILED MAY 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923 to May 16, 1923, that I last saw h in alive on May 16, 1923, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - R cerebral and third ventricle - calcified glioma

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Postoperative shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of May 16

Was there an autopsy? —

What test confirmed diagnosis? Operation

(Signed) F. H. Reichert, M. D.

5/21, 1923 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: 5/25 1923

20 UNDERTAKER: J. Luirson & Bro — ADDRESS 1127 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76088

CERTIFICATE OF DEATH.

90 D76088

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 S Carolina ST.; 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abe Posner

(a) RESIDENCE. No. 212 S Carolina ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Hebrew

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rochail Posner

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 55; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Russia.

PARENTS

10 NAME OF FATHER: Morris Posner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Joseph Posner. (Address) 1006 N Monroe St

15 Filed MAY 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 25, 1923, that I last saw h[illegible] alive on May 25, 1923, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

Acute Dilatation of Heart (duration) yrs. mos. 2 hrs ds.

18 Where was disease contracted if not at place of death? 212 S Caholine

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Adler MD M. D.

, 19 (Address) Arlington.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave., — DATE OF BURIAL: May 26 1923

20 UNDERTAKER: Jack Lewis, 1439 E Balto — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state AGE should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76089

100-001 D76089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2006 Ellsworth ST. 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Hirshauer

(a) RESIDENCE. NO. 2006 Ellsworth ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6. 5. 22.

7 AGE: Years — Months 11 — Days 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md,

PARENTS

10 NAME OF FATHER Louis Hirshauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Mary Kucera

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto! Md.

14 Informant (Address) Mrs. Mary Hirshauer 2006 Ellsworth

15 Filed MAY 25 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24. 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 6 19 23 to May 24 19 23.

that I last saw h alive on May 23 19 23.

and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Chronic Catarrhal Bronchitis (duration) yrs. 10 mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harley H. Meyer M. D.

5/24 19 23 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	May 26th 1923
20 UNDERTAKER	ADDRESS
Geo M Frill & Son	811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1921 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76090

CERTIFICATE OF DEATH.

129 D76090

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2116 Benson ST. 30 WARD)

2-FULL NAME Catherine Sophie Bonnet

(a) RESIDENCE NO. 2116 Penrose Ave ST. 30 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas C Bonnet

6 DATE OF BIRTH (month, day, and year): 9-21-62

7 AGE: Years 60 Months 8 Days 3 If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Brooklyn N.Y.

PARENTS

10 NAME OF FATHER: John Goering

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant (Address): Mr Vanderen 2116 Penrose Ave

15 MAY 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1st. 1923 to May 24. 1923.

that I last saw h alive on May 23rd. 1923.

and that death occurred, on the date stated above, at 12" Noon

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis

Uremic Convulsions

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj O McCleary M. D.

. 19 (Address) 400 N Payson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DATE OF BURIAL: May 26, 23

20 UNDERTAKER: Wm. J. Eckner & Son ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76091

CERTIFICATE OF DEATH.

118-007 D76091

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 258 N. Arlington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Annie Brown

(Residence in Baltimore: No. 258 N Arlington St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Not Known, ... (Month) ..... (Day) 1 ..... (Year)

7-AGE, 47 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Brown

(Address) 258 N. Arlington Ave

15-

Filed ....., 191.... MAY 25 1923

HOREK H. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23 (Day), 1923. (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1923, to May 23 1923, that I saw her alive on May 22 1923, and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia, Influenza

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) William E. Burdon M. D.

May 23, 1923 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn. DATE OF BURIAL, May 26, 1923

20-UNDERTAKER James N. Lewis ADDRESS 1213 Greenmount Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76092

CERTIFICATE OF DEATH.

+ 141 D76092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 25 WARD)

2-FULL NAME Mrs Ida Bowen

(a) RESIDENCE No. Arlington ave Relay Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm M. Bowen

6 DATE OF BIRTH (month, day, and year) July 30, 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46 yrs.	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 13

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jas. H. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Loretta E. Thomas.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm. M. Bowen (Address) Relay. Md.

15 MAY 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 rd 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1923, to May 23, 1923, that I last saw her alive on May 23, 1923, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis.
Endometritis

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 21 1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward H. Kurbanske, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5/26 1923
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1460 Battery Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—This Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76093

CERTIFICATE OF DEATH.

44

D76093

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1301 Greenmount Av St.; 10th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis George

(Residence in Baltimore: No. 1301 Greenmount Av St.; 67 yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 25, 1855 (Month) (Day) (Year)

7-AGE 67 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Trustee
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Francis George

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Rose Millsbrock

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Barry George

(Address) 768 Bartlett Av

15- MAY 25 1923 ROBERT R. KRAUTER, Filed....., 191..... Burial Permit Register.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 10th 1923, to May 23rd 1923, that I saw h in alive on May 23rd 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Manitou

(Duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Stomach

(Duration) 1 yrs. 1 mos. ds.

(Signed) Joseph B. Sanders M. D.

May 24th, 1923 (Address) 614 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, May 26, 1923

20-UNDERTAKER J. C. Bradefield — ADDRESS 914 Fremont Av

Foote

Spec.—1-10-21—M&T—1500 Blks.

D76094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D76094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital Lafayette & John ST. 14 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Corbett

(a) RESIDENCE NO. ..... ST., ... WARD Pikesville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24, 1923

7 AGE: Years ..... Months ..... Days 13 hours If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... (illegible)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Womans Hospital
(State or country) Balto - Md.

PARENTS

10 NAME OF FATHER Robert Joseph Corbett

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Violet M. Upman

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Robert Corbett
(Address) Pikesville Md

15 MAY 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to May 25, 1923, that I last saw him alive on May 25, 1923, and that death occurred, on the date stated above, at 3 30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. Cole Warfield, Jr. M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: May 25 1923

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76095

D76095

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 N Arlington ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Fennrick

(a) RESIDENCE No. 1001 N. Arlington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-20-23.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...0...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Charles Fennrick

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mildred Warner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wash. D.C.

14 Informant
(Address)

15 Filed MAY 25 1923 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23. 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-20- ,1923. to 5-23 ,1923.

that I last saw her alive on 5-23 ,1923

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis Congenital

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Parsons, M. D.

(Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAY 25 1923

20 UNDERTAKER Commissioner Health.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76096

CERTIFICATE OF DEATH.

37-902 D76096

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2630 E. Monument ST., WARD)

2-FULL NAME Robert F. Garrett

(a) RESIDENCE NO. 2630 E. Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie M. Garrett

6 DATE OF BIRTH (month, day, and year): Jan 7, 1877

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

059

9 BIRTHPLACE (city or town) (State or country): Holland

PARENTS

10 NAME OF FATHER: Bernard Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Holland

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Annie M. Garrett

(Address) 2630 E. Monument

15 May 25 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 1923, to May 24 1923,

that I last saw him alive on May 24 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

5 (Signed) Theobald Mayer M. D.

25, 1923 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: May 28 1923

20 UNDERTAKER: Burklart & Burklart — ADDRESS: 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE DATA REQUIRED EXACTLY. PHYSICIANS should be stated EXACTLY. mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D76097 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 44 D76097

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2524 Boyd ST. 20 WARD)

2-FULL NAME Martin J Scharf

(a) RESIDENCE NO. 2524 Boyd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Anna C. Scharf.

6 DATE OF BIRTH (month, day, and year) Jan. 7-1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
50	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John A. Scharf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdelena Hotel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Anna C. Scharf. (Address) 2524 Boyd St.

15 Filed MAY 25 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 24, 1923.

that I last saw him alive on May 24, 1923

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows: Carcinoma of Oesophagus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Rec'd

(Signed) Howard W Jones, M. D.

May 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bayview Cathedral DATE OF BURIAL May 26 1923

20 UNDERTAKER George Schwartz Frederick ADDRESS

B.—WRITE PLAINLY, WITH INKING IN mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See Instructions on back of certificates. should be stated EXACTLY. PHYSICIANS should may be properly classified. Exact statement of

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76098

CERTIFICATE OF DEATH.

31 D76098

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 E 23d ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Cochran

(a) RESIDENCE NO. 540 E 23d St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth?* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 12 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typewriter

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Wm J. Cochran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Mary L Cochran
(Address) 540 E 23 St.

15 MY 25 1923 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/23 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/22, 1923, to 5/23, 1923, that I last saw h[er] alive on 5/23, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr Bernard Sachs, M. D.

5/24, 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St Johns Balto Co — DATE OF BURIAL May 26 1923

20 UNDERTAKER C A Wiedefeld Jr — ADDRESS 501 E 22 St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec. 1-19-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76099 ✓ D76099

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 McCulloh ST., 11 WARD)

2-FULL NAME Mary McFaul Miller

(a) RESIDENCE NO. 1226 McCulloh ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~
~~HUSBAND of~~ (or) WIFE of Irving C. Miller

6 DATE OF BIRTH (month, day, and year) 1851-10-31

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	71	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles McFaul

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Louis Mo.

12 MAIDEN NAME OF MOTHER Leonora A Judik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Edw J. Seafer
(Address) St Paul & Fayette Sts

15 MAY 25 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1923

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1923, to May 24, 1923, that I last saw ~~him~~ her alive on May 24, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic tuberculosis Intestines
+ Myocarditis with
arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Treated

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? 0 Date of 0

Was there an autopsy? 0

What test confirmed diagnosis? none

(Signed) [illegible] M. D.

, 19 (Address) 804 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL May 26 1923

20 UNDERTAKER Henry A Watkins Sons

ADDRESS McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-2 — E.H.R.S.—400 Blks.

D76100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76100

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Elder

(a) Residence No. Bay View Asylum. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1854

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Sykesville (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Levi M. Elder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Cordilia Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Municipal Hospital Record

(Address)

15- Filed Robert F. Harrison, Registrar.

MAY 25 1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 21, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1923 to May 21, 1923 that I last saw him alive on May 21, 1923, and that death occurred, on the date stated above, at 6:00 A.M. The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Duration) yrs. mos. 6 hrs

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Powell M. D

5-21 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. May 25, 1923

20-UNDERTAKER. J. B. Cook

ADDRESS 1038 Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important ... instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76101 D76101 ✓ D76101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME William Bellamy

(a) RESIDENCE NO. 628 Jasper ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'H

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Ella —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed MAY 25 1923, 19 Robert F. Harrison, Burial Permit Clerk (43.5) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1923, to May 19th, 1923, that I last saw h~~e~~ alive on May 19th, 1923, and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Type IV

(duration) ... yrs. mos 12 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) E. Cowles Andrus, M. D.
, 19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAY 25 1923

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL Commissioner Health Asst. Wm. E. Woodall

MAY 25 1923

MAY 25 1923

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—M. P. Co.—1000 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76102

CERTIFICATE OF DEATH.

D76102

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1717 Covington ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shelton Lee Ferrell

(a) RESIDENCE. NO. 1717 Covington ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Ferrell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mollie White

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mother
(Address) 1717 Covington St

15 Filed MAY 25 1923 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to May 25, 1923, that I last saw him alive on May 25, 1923, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping cough (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam.

(Signed) M. L. Lubtubery, M. D.

5/25, 1923 (Address) 1717 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: 5/26 1923

20 UNDERTAKER: J. Few McCulley

ADDRESS: 130 E. Fort

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76103

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D76103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 800 So. Milton ave St., Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Steve Jagielski

(Residence in Baltimore: No. 800 So Milton ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. May 24 1923 (Month) (Day) (Year)

7-AGE. ... yrs. ... mos. ... ds. If LESS than 1 day, 17 hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Joseph Jagielski

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Gertrude Kowox

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Jagielski

(Address) 800 So. Milton ave

15- ... 1923 Robert P. Harrison, Registrar.

Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 24 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... Prematurity on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Horton M. D. (Coroner.)

May 25 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary

DATE OF BURIAL. 5/28, 1923

20-UNDERTAKER. Wm Fredsow Jr.

ADDRESS. 1618 Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76104

CERTIFICATE OF DEATH.

90 D76104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4813 Brightwood ST., 28 WARD)

2-FULL NAME Dorothy W. C. Auld

(a) RESIDENCE NO. 4813 Brightwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 20 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER J Conrad Waechter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Fuhrer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry E. Auld

(Address) 4813 Brightwood Ave

15 MAY 26 1923 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1923, to May 24, 1923, that I last saw h... alive on May 24, 1923, and that death occurred, on the date stated above, at 1030 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible], M. D.

(Address) 2406 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 26 1923
20 UNDERTAKER	ADDRESS
James B. Hayes	324 Eutaw Pl

GE should be stated EXACTLY. PHYSICIANS should
t it may be properly classified. Exact statement of OCCU
on back of certificates.
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b
matien should be carefully supplied. AGE sh
WRITE PLAINLY, with pen and ink.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76105 HEALTH DEPARTMENT—CITY OF BALTIMORE D76105

91-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No 2117 N. Calvert St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Mills Peace

(a) Residence No 2117 N. Calvert St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 20 1838

7-AGE, 84 yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired.

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ellicott City Md

PARENTS.

10-NAME OF FATHER, Cyprial Mills

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Frusha Kilbourn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-(Informant) Thomas Bell

(Address) Hopkins Place

15-(Date) May 26 1923 Robert P. Harrison, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 24- 23

17. I HEREBY CERTIFY, That I attended deceased from May 15 1923, to May 24 1923, that I last saw h. alive on May 24 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY Pneumonia (Secondary)

.....(Duration).....yrs.....mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) C. B. Garnett Jr M. D.

, 19 (Address) 2 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Green Mount	May 26, 1923
20-UNDERTAKER.	ADDRESS
John O. Mitchell	1201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

163782 ~~D76106~~ HEALTH DEPARTMENT—CITY OF BALTIMORE D76106

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 12 WARD)

2-FULL NAME Faith Jones.

(a) RESIDENCE NO. 1562 Clifton Ave. City. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Jones (father).

6 DATE OF BIRTH (month, day, and year) July 2, 1922.

7 AGE — Years: — Months: 10 Days: 23

If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): JOHNS HOPKINS HOSPITAL Records

15 MAY 26 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1923. to May 25, 1923. that I last saw her alive on May 24, 1923. and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following measles.

(duration) 0 yrs. 0 mos 14 ds.

CONTRIBUTORY (Secondary) Cerebral thrombosis

(duration) 0 yrs. 0 mos. 5 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes Post mortem examination of organs.

What test confirmed diagnosis?

(Signed) William H. F. Wartiew, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexandra Va — DATE OF BURIAL: May 28 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76107

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 Monroe St., 10 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Link

(a) Residence No. 715 Monroe St., Ward 10
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Geo Link

6-DATE OF BIRTH (month, day and year) June 29 1843

7-AGE, 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14- (Informant) Mrs Seaman

(Address) 730 Monroe St.

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May - 24-23

17- I HEREBY CERTIFY, That I attended deceased from 3/11, 1923, to 5/24, 1923, that I last saw h. alive on 5/23, 1923, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis

Duration (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

Unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Bosman Welsh, M. D.

5/24, 1923 (Address) 614 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL, Greenmount May 26, 1923 DATE OF BURIAL,

20-UNDERTAKER, Wm Cook ADDRESS 502 E Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5/26 1923

Spec.—1-10-21—M&T—1500 Blks.

D76108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76108

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 E Lafayette Av St., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Nickel

(a) RESIDENCE NO. 1418 E Lafayette Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
		9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm V. Nickel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Isabella Doe

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant William V. Nickel
(Address) 1418 E Lafayette Ave

15 Filed MAY 26 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1923

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to May 25, 1923,

that I last saw h[illegible] alive on May 25, 1923,

and that death occurred, on the date stated above, at 3 00 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Auto Intoxication
& Convulsions

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Intestinal Auto Intoxication

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C C J Carman, M. D.

5-26, 1923 (Address) 1702 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL 5/28 1923

20 UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK. Every question should be carefully answered. AGE, PLACE OF DEATH and CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should note that information should be carefully supplied. AGE, PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76109 HEALTH DEPARTMENT—CITY OF BALTIMORE D76109

CERTIFICATE OF DEATH. 146

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 2833 Huntingdon Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie C. Coleman

(a) Residence No. 2833 Huntingdon Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Nelson R Coleman

6-DATE OF BIRTH (month, day and year) Nov 20 1886

7-AGE, 36 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Jeremiah Shaw

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Nelson R Coleman

(Address) 2833 Huntingdon Ave

15- Filed Robert P. Harrison, 192 Registrar.

Burial Permit Book.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 24/23

17- I HEREBY CERTIFY, That I attended deceased from May 13 1923 to 24th 1923 that I last saw h.. alive on 5/24 1923 and that death occurred, on the date stated above, at 1130P m.

The CAUSE OF DEATH* was as follows:

Cystitis Pyonephritis

following chronic

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 11 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry F Cassedy M. D.

, 19 (Address) 1 Colonial Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, REMOVAL. New Freedom DATE OF BURIAL, May 27 1923

20-UNDERTAKER. ADDRESS

Greenwood & Gelston Chestnut & Lake

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 26 1923

(Olubala)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76110

CERTIFICATE OF DEATH.

21 D76110

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 1 WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME ~~2904 O'Donnell~~ Victoria Olubala

(Residence in Baltimore: No. 2902 O'Donnell St.; 30 yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Nov 1st, ~~1890~~ 1889
(Month) (Day) (Year)

7-AGE 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Poland.

PARENTS.

10-NAME OF FATHER: Geo. Mackowska

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Olubala

(Address) 2902 O'Donnell

15- Robert P. Harrison, Registrar.

MAY 26 1923 Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Erysipelas Facial + 3 weeks

Nephritis — Contributory

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus in blood stream & tissues

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

May 27, 1912 (Address) 1159 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem	May 28, 1912
20-UNDERTAKER	ADDRESS
Stephen J. Hackowski	1020 N. Kenwood Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.